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Auditor General for Wales

Clinical coding follow-up review – **Cwm Taf University Health Board**

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The person who delivered the work was Emily Howell.

Contents

Although accuracy has improved, the Health Board is not achieving its completeness target and has a significant coding backlog.

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 forms 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 January 2014, we reported our findings for Cwm Taf University Health Board (the Health Board) and concluded that 'While there had been a strong focus on improving the timeliness of management information, a range of weaknesses in the clinical coding arrangements and process were significantly reducing the accuracy of clinical coded data and backlogs in uncoded episodes were now increasing'. More specifically, we found that:

- clinical coding had a high profile at Board level, but coding needed more investment and there needed to be a greater focus on quality and accuracy;
- the quality of clinical coding was weakened by poor quality medical records, aspects of staff management and a lack of clinical engagement and audit processes; and
- clinical coded data was used appropriately and met the Welsh Government standards for 2012-13 but backlogs of uncoded episodes were increasing

[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).

and there were significant problems with the accuracy of coding, the implications of which needed to be clearly identified to the Board.

7 We made several recommendations, which focused on:

- improving the management of medical records;
- strengthening the management of the clinical coding teams;
- strengthening engagement with medical staff; and
- building on the good engagement that already exists with the Board.

8 As part of the Auditor General's 2018 audit plan at Cwm Taf University Health Board, we 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:

- 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 although accuracy has improved, coding completeness is an issue. There has been some progress against our previous recommendation however coded data is not yet being used by the Health Board to its full potential.

Although accuracy has improved, the Health Board is not achieving its completeness target and has a significant coding backlog

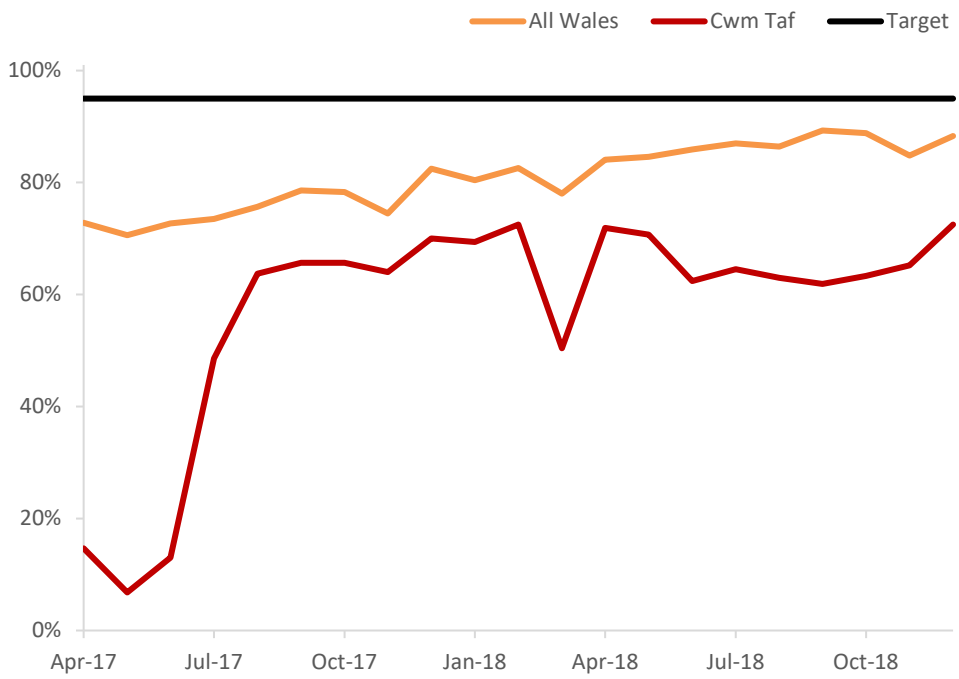
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

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 15 responses out of a possible 22 responses were received.

financial year which was previously the case. Based on this data, Exhibit 1 shows that Health Board's completeness has improved but is still not meeting the target, and is well below the all-Wales average.

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



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

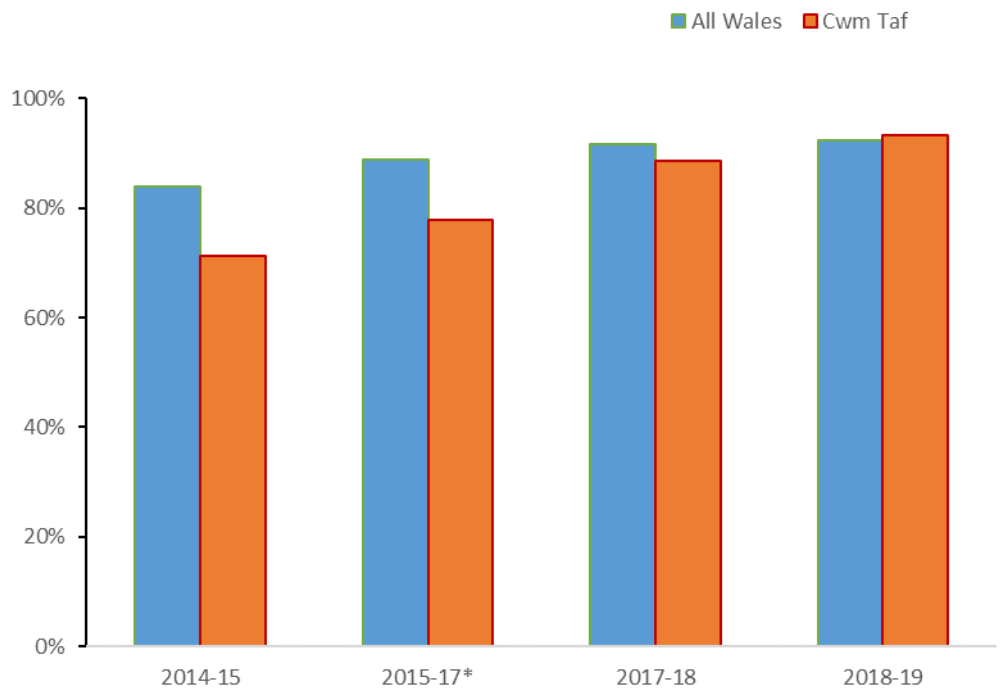
14 As part of our fieldwork, we requested the backlog position as at March 2018. The Health Board reported a small backlog of 1.87% Finished Consultant Episodes (FCEs), equating to 1,963 FCEs. Since then, the backlog position has deteriorated. The March 2019 performance report to the Board indicates a backlog position at December 2018 of 20,792 FCEs. The Health Board are employing agency and contract coders to assist in clearing the backlog as well as utilising overtime. However further funding will be required if the Health Board is to achieve the Welsh Government target. In addition, the Health Board has significant staffing pressures. There are high levels of sickness and absence, and retention of coders is still an issue.

15 Coding staff told us that conditions within the teams and recent issues with management and supervisory staff were having a detrimental effect on staff morale. This included concerns about the recent increase in workload, a lack of training support and poor communication. The Health Board is aware of these

issues, and the teams have subsequently received some additional HR support including team building activities.

16 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 Health Board's accuracy has improved and is above the Wales average.

Exhibit 2: percentage of episodes coded accurately



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

The full potential of coded data to inform service improvement is yet to be realised

17 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.

18 The profile that coding has within the Health Board is positive, with the Director of Planning and Performance continuing to act as a coding champion. The Health Board is using coded data to inform elements of service planning and improvements. For example, length of stay initiatives in relation to total knee replacements and work on caesarean section rates. However, the extent to which the data is being used is limited, which is recognised by the operational lead for coding.

19 The benefits of coded data to clinicians, for example, have not yet been realised. These include supporting medical revalidation and being able to identify trends in diseases or prevalence within the population.

The Health Board has made progress against our previous recommendations but some areas need further attention

20 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
17	6	9	2	-

Source: Wales Audit Office

21 Our follow-up work found that the Health Board has made some progress against our 2014 recommendations, but many of our recommendations require further work to fully address them.

22 Since our 2014 review, there has been little change in the management of medical records. There continue to be issues with the quality of medical records which could affect the ability of clinical coders to undertake their role. The Health Records Committee was re-established at the time of our previous work, which was positive as it helped formalise engagement between coding and health records. However, this Committee was disbanded in August 2017 and no other arrangements were put in place. We are aware that the Health Board is undertaking a Clinical Audit review of the quality of documentation in case notes. This is due to report in March 2019.

23 As mentioned in paragraph 14, staffing levels within the coding department have been an issue for the Health Board. This was raised in a 2017 Internal Audit report, and again in a recent performance report to the Board. Whilst the Health Board has taken positive steps to recruit trainee coders, the impact of these staff on

productivity and subsequent achievement of the completeness target will take some time as they develop their skills.

24 To improve coding accuracy, the Health Board did support the supervisor at the time to attain the national clinical coding audit qualification which would have supported a local programme of coding audit. However, the member of staff has since left for a national role and the current supervisor does not meet the eligibility criteria in order to apply to obtain the qualification. A performance development review process is in place to provide more informal feedback on issue, and feedback is given to staff. However, communication has been raised as an issue.

25 Clinical engagement has been described as the single most valuable resource to a coding department. In our previous report, we highlighted that there was limited clinical engagement in coding. Unfortunately, the team weren't unable to make much progress in this area due to staff capacity and a lack of engagement from clinical staff.

26 Board engagement on coding issues continues to be good, and the quality and depth of the information on coding performance has improved since our last review. Board members in our survey were satisfied with the information they received on clinical coding. However, more could be done to inform the board on the wider importance of coding, the implications of poor clinical coding and the impact of the coding backlog. The full board survey results are available in Appendix 2.

Recommendations still outstanding

27 In undertaking this work, we have made one additional recommendation. This is set out in Exhibit 4. However, 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 recommendation

2019 Recommendation	
Clinical Coding Resources	
R1	Develop a training plan for Coders to support all levels of staff to develop and progress their careers.

Exhibit 5: 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 support the clinical coding process. This should include: a) raising the importance of good quality medical records throughout the Health Board; b) clarifying roles and responsibilities for medical records amongst clinical support staff, such as ward clerks and medical secretaries, including filing and general record maintenance; c) developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving; and e) putting steps in place to ensure that medical records are released to clinical coding teams as soon as possible after discharge.
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) setting out a clear plan for succession planning of staff over the next five years, which will provide an opportunity for developing a clear career pathway and implementation of the accredited clinical coder qualification; b) providing support for members of the team to achieve the clinical coding auditor qualification, and the implementation of a local programme of clinical coding audits; and e) using opportunities presented by team meetings and individual appraisals to provide regular feedback to staff on issues raised through validation and audit.
Engagement with Medical Staff R3 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) raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings such as audit sessions; and c) encouraging clinical coding staff to engage clinicians in the validation process and to visit clinical areas.

2014 recommendations not yet complete
Board Engagement R4 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. a) providing short briefing material which clearly sets out the implications of poor clinical coding (reflecting timeliness, completeness and accuracy) on key performance indicators; and b) ensuring that papers that are underpinned by clinical coding data, such as the performance management report, planning documents include a statement which sets out the robustness of the data.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 6: 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) raising the importance of good quality medical records throughout the Health Board;	Not specified by the Health Board	Overdue	In 2014, we found that the quality of medical records across the Health Board was not of a good standard, with key information required for accurate clinical coding often missing or inappropriately filed. Our work has found that there continues to be issues with the quality of medical records within the Heath Board. In 2018, NWIS produced a report into clinical coding documentation. This review was undertaken as part of ongoing service improvement work to improve the quality of clinical coding data. The primary aim of this review was to assess the quality of the clinical documentation held within case notes. Overall administrative documentation was of good quality, but there were issues with loose paperwork and records being filed out of order. There were also issues with deceased notes and unplanned admissions. The quality of information for coders in the notes was poor. Only half of the clinical entries contained a diagnosis and of these, a third would be unable to be used for coding purposes. This report highlights that there are issues that need to be addressed by the Health Board.

Recommendation	Target date for implementation	Status	Summary of progress
			In our 2014 report, we noted the re-establishment of the Health Records Committee. The aim of this was to give the necessary focus to the quality of medical records to enable coders to code accurately. However, this Committee was disbanded in August 2017 and we are unaware of any new arrangements in place to monitor and ensure the quality of medical records.
b) clarifying roles and responsibilities for medical records amongst clinical support staff, such as ward clerks and medical secretaries, including filing and general record maintenance;	Not specified by the Health Board	Overdue	The review in 2014 highlighted that the medical records team had responsibility for setting up the record and ensuring that it is stored correctly. These arrangements have continued with medical records retaining responsibility for the movement and storage of files but not the contents. We are not aware of any specific work undertaken to clarify the role and responsibilities for medical records for any other staff.
c) developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving;	Not specified by the Health Board	In Progress	The quality of the patient record has a direct impact on the coders ability to undertake their role. As highlighted previously, work by NWIS into the quality of documentation highlighted concerns with loose paperwork, and the filing of deceased patient records. As part of the annual clinical audit and effectiveness plan, there is currently a Health Board wide audit of the quality of case notes. This audit is looking at documentation in case notes and is aligned to the health records committee, however this committee has been disbanded so we are unsure where the results of this audit are reviewed. The current audit plan shows that this audit was also undertaken last year but there is no record of the report. The results of the current audit are due for publication in March 2019.
d) reviewing the arrangements for filing result slips in medical records, taking into consideration the electronic reporting function of clinical systems; and	Not specified by the Health Board	Implemented	In 2014, we found that there were issues releasing medical records to the coding teams because of a backlog in results slips being filed. This has now been resolved and results slips are no longer filed in medical records as they are available electronically.

Recommendation	Target date for implementation	Status	Summary of progress
e) putting steps in place to ensure that medical records are released to clinical coding teams as soon as possible after discharge.	Not specified by the Health Board	In progress	Our 2014 review found that on average coders were getting access to medical records within 6 weeks of discharge, but some could take longer than three months to reach the department. Currently the Health Board is undertaking mapping work to understand where medical records are going. They recognise that coders need timely access to the records to meet the completeness target. Coders are working to get notes directly from the wards but sometimes they need to be requested from the central hub at Williamstown. There is a positive working relationship between medical records and coders and recognition why coders need timely access to the records. The hub is open 7 days a week and medical records allow contract coders to work directly from the hub on weekends to address the backlogs.
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) setting out a clear plan for succession planning of staff over the next five years, which will provide an opportunity for developing a clear career pathway and implementation of the accredited clinical coder qualification;	April 2014	In progress	Staffing levels have been problematic for the coding teams. In our 2014 report we highlighted that there was a shortfall in the staffing establishment. In 2017, Internal Audit also raised concerns around the shortfall in staffing levels and the ability of the team to efficiently process the volume of hospital episodes and to meet the Welsh Government target. The Health Board has recognised this issue and has included a workforce plan in the strategy for the development for the clinical coding department. This strategy is set out clearly within the Integrated Medium-Term Plan for the Performance and Information Directorate. The Health Board has also introduced formal 'Annex U'[3] clinical coder training posts which are supported by a structured two-year

[3] Annex U is a NHS arrangement for trainees who are undertaking on the job training, Renumeration for new starters is a percentage of the Band 4 salary in line with Annex U Agenda for Change rules and once qualified they receive the full Band 4 salary.

Recommendation	Target date for implementation	Status	Summary of progress
			internal training programme. These posts are trainee roles, and staff are appointed on an initial 24-month contract during which time the individual will be supported to work towards accreditation. The increase in trainee role however does not increase productivity significantly and can have a detrimental impact, as qualified coding staff need to support and check their work. Trainees also reported that they felt there was not enough support for them during their training to prepare them for exams. They also reported that there is no formal structure to the training or milestones to work towards and keep track of progress. The Health Board needs to consider how it will support all levels of staff to develop and progress their careers.
b) providing support for members of the team to achieve the clinical coding auditor qualification, and the implementation of a local programme of clinical coding audits;	March 2015	In progress	In 2014, we found that there was no local programme of clinical coding audit and a lack of a qualified clinical coding auditor within the Health Board meant that this could not be put in place. Since then, the Health Board did support an individual to attain the audit qualification, however they gained promotion into a national role soon after qualifying. The Health Board recognise this gap in their team, have been unable to find a coding course for them to achieve the qualification.
c) reviewing the allocation of workload across the teams to ensure that clinical coding demand is evenly distributed;	Not specified by the Health Board	Implemented	The allocation of workload has remained consistent with our review in 2014. The Health Board has a general approach across the clinical coding teams at the two district general hospital sites. Coders take the records in chronological order to code regardless of the speciality to which the episode relates. Trainees rotate through the specialties to give them experience. The Health Board has undertaken an external benchmarking exercise in order to understand its comparative position on workload and is using this to determine the team requirements.
d) encouraging whole team meetings which bring together all clinical coding staff from across the sites;	Not specified by the Health Board	Implemented	A whole team meeting for all sites was trialled and this completed in September 2016.

Recommendation	Target date for implementation	Status	Summary of progress
e) using opportunities presented by team meetings and individual appraisals to provide regular feedback to staff on issues raised through validation and audit; and	Not specified by the Health Board	In Progress	A PDR process is in place which gives a chance for feedback to staff on issues raised through routine validation. Additionally, there is regular information available on staff productivity through an electronic system which is used across the Health Board. However, there is currently no clinical coding qualified auditor within the team, so there are no regular case note audits being undertaken.
f) monitor and manage high levels of productivity to ensure that the need for timeliness does not impact on the accuracy of clinical coding.	Not specified by the Health Board	Implemented	Regular information on staff productivity is available through CHKS reports which enables any areas of concern to be highlighted. Within coding, there is a recognised standard workload of 30 FCEs per day per full time coder. However, the Health Board has decided to increase the workload target to 40 FCEs per day, which is 10 higher than the NWIS recommendation. The Health Board needs to be mindful that this does not negatively affect the quality of coding by putting staff under increased pressure to code more activity, although the NWIS accuracy scores have improved over time which is positive. The Health Board has undertaken its own benchmarking exercise and feels there is scope to improve productivity.
Engagement with medical staff R3 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) raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings such as audit sessions;	Not specified by the Health Board	In progress	In 2014, we highlighted there was limited clinical engagement in clinical coding. Since then, the Health Board has attempted to raise awareness of clinical coding by attending sessions with clinical staff, for example recent engagement with ENT consultants but the extent to which this has happened has been limited and adhoc. Staff capacity within the coding team has been identified as the main reason for this.

Recommendation	Target date for implementation	Status	Summary of progress
b) raising the awareness of the location of the clinical coding teams across the sites; and	September 2014	Implemented	In response to our 2014 recommendation, it was identified that a departmental open day would be held to allow staff the opportunity to review coding systems, books and results. This was undertaken and a leaflet produced which outlined the basics of the team and the locations.
c) encouraging clinical coding staff to engage clinicians in the validation process and to visit clinical areas.	Not specified by the Health Board	In Progress	An identified model of good practice is to engage clinicians in the validation process. However, staff are reporting issues with accessing clinicians because it is time consuming and they often do not get a reply. The coding team however have established a single point of contact in ENT for coding queries, but this appears to be the only arrangement that is in place. The team have presented at the Medical Leadership Forum which is positive. Where engagement occurs elsewhere, this appears to be reactive to concerns about the quality of coding. For example, cardiology approached the coding team when they were receiving data which did not match what they were expecting. This discussion has however provided an opportunity to raise the importance of good quality case notes to support the coding process.
Board engagement R4 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.			
a) providing short briefing material which clearly sets out the implications of poor clinical coding (reflecting timeliness, completeness and accuracy) on key performance indicators;	Not specified by the Health Board	In progress	The Health Board has maintained its surveillance of its coding performance, and both completeness and accuracy feature as part of the Health Board's key performance indicators which are reported to Board. The detail and benchmarking information in these have improved since our last review. The information highlights the backlog and the actions being taken. However, the report does not explicitly highlight the impact the backlog has on the quality of data.

Recommendation	Target date for implementation	Status	Summary of progress
			Although board members were broadly satisfied with the information, they receive in the robustness of clinical coding arrangements 87% of those responding said they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information. Since our previous work, the Health Board has had considerable churn of Independent Members who may benefit from training on clinical coding.
b) ensuring that papers that are underpinned by clinical coding data, such as the performance management report, planning documents include a statement which sets out the robustness of the data	Not specified by the Health Board	In Progress	In our original review there were regular performance reports to the Board in respect of coding. At the time these reports were highlighting significant backlogs in coding activity. The levels of backlog were not dissimilar to the current reported position in March 2019. At the time, the risks to other reported performance data because of clinical coding backlogs was identified as an extreme risk and featured in the Health Board's corporate risk register. Clinical coding does not currently feature on the Health Board corporate risk register although it is on the team local risk register. The level of performance is of concern and is currently the lowest in Wales. The team need to be mindful that where information could be affected by the completeness of coding that this is highlighted effectively.
c) alongside the clinical coding performance for the rolling 12-month period, providing the total level of uncoded activity which is outstanding from previous periods.	April 2014	Implemented	There have been considerable improvements to the level of information included in the performance reports produced by the Health Board since our original review. Detailed exception reports are produced which show the current, historical and comparative benchmark position against other Health Boards in Wales. The total level of uncoded activity is now included on the performance report which makes it clearer to see for all periods.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from 15 of the board members in the Health Board.
The breakdown of responses is set out below.

Exhibit 7: 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	8	34	8	40
Neither satisfied nor dissatisfied	7	46	7	46
Dissatisfied	-	10	-	4
Completely dissatisfied	-	-	-	1
Total	**15**	**96**	**15**	**96**

Exhibit 8: 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	6	26
Some awareness	5	50
Limited awareness	3	17
No awareness	1	3
Total	**15**	**96**

Exhibit 9: 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	1	8	13	77
No	14	84	2	19
Total	**15**	**92**	**15**	**96**

Appendix 3

Management response

Report title: Clinical Coding Follow-up Review

Completion date: March 2019

Document reference: 1180A2019-20

2019 Recommendation

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Clinical Coding Resources** Develop a training plan for Coders to support all levels of staff to develop and progress their careers.	To develop clear career pathways and support clear succession planning	Yes	Yes	Our training plan has evolved over the last two years and we now have a single ACC qualified supervisor providing a dedicated supported to all trainees. This provides consistency and continuity to their training programme. Once the eligibility criteria are met, this supervisor will study for both the official training and auditor qualifications. In addition, in accordance with	Ongoing as part of the training plan to meet the expected date when trainees will sit the exam. As required	Assistant Director of performance and Information, Head of Benchmarking Clinical Coding Manager

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					national guidelines, all team members attend refresher training and workshops as outlined within the NWIS training programme. These dates are all recorded against individual ESR records. The succession planning arrangements are detailed in the IMTP. The plan involves having a dedicated supervisor on each site, as well as a dedicated auditor post. The planned structure clearly shows the potential for progression through the Department, with internal applications for advertised posts being encouraged and welcomed at all times.	IMTP 2020/21	

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