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Clinical coding follow-up review – **Powys Teaching Health Board**

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Contents

The Health Board performs very well against the all-Wales targets for clinical coding with good quality coded data and no backlog. It is starting to use coding data to support improvement but needs to do more to implement some of our previous recommendations, particularly improving the profile of coding, clinical engagement with the coding function and raising the quality of 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 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 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 Powys Teaching Health Board (the Health Board). The report concluded that 'Clinical coding lacked any prominence within the Health Board and although arrangements supported the generation of timely information, a range of weaknesses in the process were impacting on the accuracy of clinical coded data.' More specifically, we found that:

- although there was potential to extend the scope of activity, the Board did not see the value of coding to the effective operation of its business;
- despite the general procedures by which activity is coded working well, there were some significant gaps in the overall clinical coding process particularly in relation to clinical engagement and validation checks; and
- clinical coded data was used appropriately and met the Welsh Government standards but there were problems with the accuracy of coding, the implications of which needed to be clearly identified to the Board.

[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 recommendations focused on:

- raising the profile and awareness of clinical coding across the Health Board;
- ensuring processes were in place to routinely validate and review the accuracy of coding;
- reviewing the allocation of staff resources, work programmes and improving team working; and
- improving the quality of medical records across the Health Board.

8 As part of the Auditor General's 2018 audit plan at Powys Teaching 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 Our overall conclusion is that **the Health Board performs very well against the all-Wales targets for clinical coding with good quality coded data and no backlog. It is starting to use coding data to support improvement but needs to do more to implement some of our previous recommendations, particularly improving the profile of coding, clinical engagement with the coding function and raising the quality of medical records.**

Clinical coding performance is good and completeness is the best in Wales

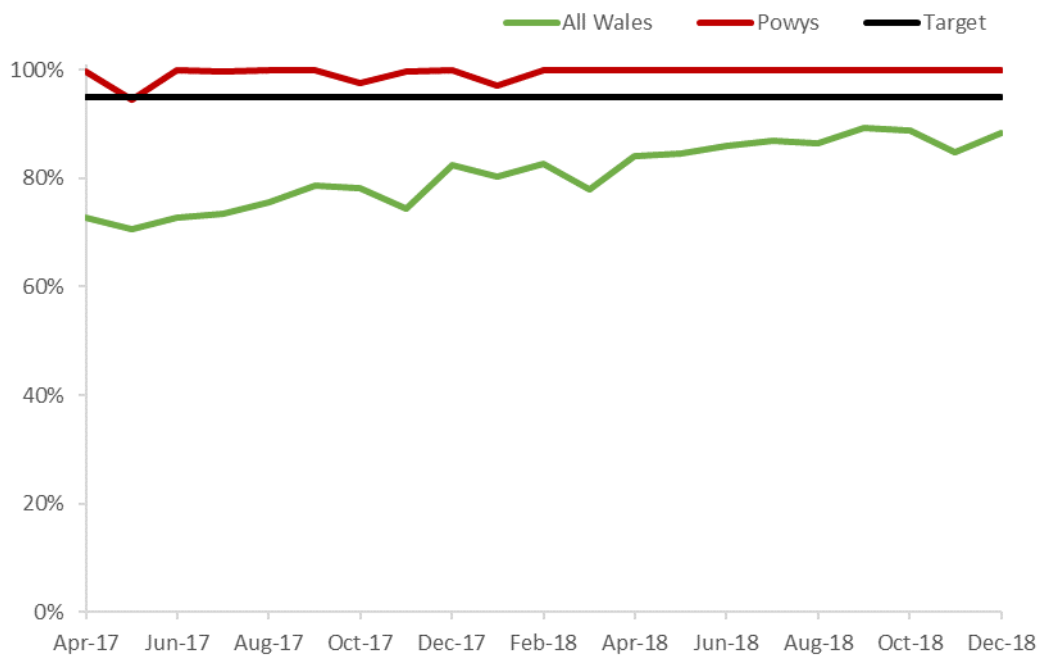
12 The Health Board is largely a commissioning organisation and provides 25% of services to patients with the remainder commissioned from elsewhere. Coding staff are individually based in Bronllys, Llandrindod Wells, Llanidloes and Ystradgynlais hospitals, and are each responsible for coding all the activity which takes place in their respective hospital plus surrounding hospitals.

[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 19 responses were received.

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

14 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 financial year, which was previously the case. Exhibit 1 shows that the Health Board's completeness has improved and is consistently high, with only one month in early 2017 where it dropped below the Welsh Government target.

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



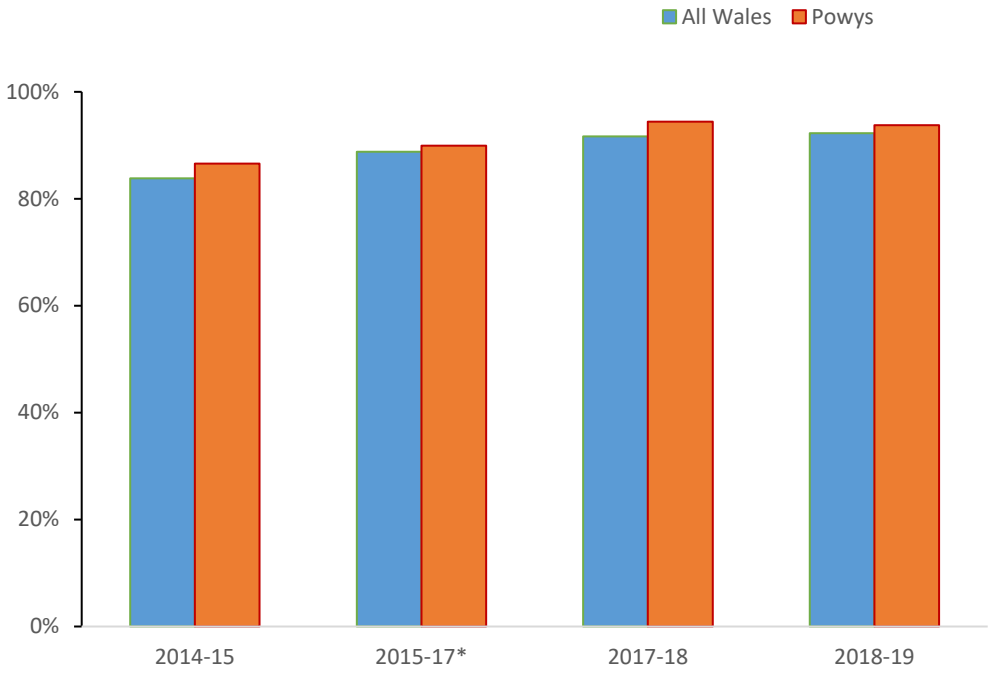
Source: Wales Audit Office analysis of clinical coding data reported by health bodies to the Welsh Government.

15 As part of our fieldwork, we requested the year-end backlog position as at March 2018. With all patient episodes being coded within one month of the episode being completed, the Health Board was in the positive position of being able to report no backlog.

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 records 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 over the last five years, albeit a minor deterioration in 2018-19 but performance is still better than the Welsh average.

Exhibit 2: percentage compliance with the Welsh Government's target for NHS bodies to demonstrate improvements in clinical coding accuracy over time



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 periods 2015-16 and 2016-17.

Clinical coded data is starting to be used to support improvement

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

18 The Health Board is using coded data to inform some elements of service planning. The Health Board is monitoring the coding performance of provider organisations, which is positive both from a financial perspective but also to understand quality and safety implications. It has also started to use the coded data in discussions with provider organisations, with a view to ensuring quality but also to assess the potential for repatriation of services back to the Health Board.

19 Since our previous work, the Health Board has expanded the activity which is coded. The team have been working with relevant specialists to now code the new nurse-led ENT clinics and the nurse-led manometry clinics. The coded data provides useful intelligence to help monitor and plan these services.

20 The benefits of coded data to clinicians, however, have not yet been realised. These include supporting medical revalidation and being able to identify trends in diseases or prevalence within the population. Clinical engagement has been described as the single most valuable resource to a coding department. The main source of information for clinical coders is derived from the medical record, and it is clinicians that act as a local resource in helping coders understand the clinical information relating to diagnoses and treatment. It is therefore important that clinicians and coders engage to improve record keeping, confirm codes and provide clinical leadership in identifying and coding co-morbidities. Our previous review found that there was no clinical engagement with clinical coding. Clinical engagement remains a challenge for the coders in the Health Board as the majority of clinicians who provide care in the community hospitals are either not employed by the Health Board or are general practioners (GPs). Unfortunately, engagement with clinicians on coding remains limited with examples of only a handful of individual conversations being held with consultants being identified.

Several of our previous recommendations have been implemented but more work is required to further raise awareness with board members, engage clinicians in the process and improve the quality of medical records

21 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
21	8	8	4	1

Source: Wales Audit Office

22 Our follow-up work has found that the Health Board is making satisfactory progress against our 2014 recommendations.

23 The profile of clinical coding within the Health Board has improved. Regular reports on coding performance in terms of completeness and accuracy are now submitted to the Board. The coding portfolio now sits with the Director of Finance who acts as a clinical coding champion at the Board. However, there remains scope to provide more training and awareness to board members on coding, its uses and importance. This is supported by the findings from our Board member survey where six out of eight respondents to the 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.

24 Little progress has been made on improving engagement and training with medical staff. Many of the Health Board's medical staff are visiting from elsewhere which presents challenges, however, there remains a need for the Health Board to engage its clinicians on coding, as the quality of information recorded in the medical record by clinicians is crucial to ensuring high quality coded data. The increased visibility of the clinical coders at Brecon Hospital, which previously lacked any coding presence despite the inpatient throughput at the hospital, will provide an opportunity to increase engagement with medical staff as coding teams will be more visible to them.

25 To ensure that clinical coded data submitted centrally is of a good quality, it is important that health boards have appropriate mechanisms in place to verify and validate the data as it is processed. We previously found that routine validation of coding was limited, however, validation processes for clinical coding have improved since our previous work. Routine validation checks are taking place with errors routinely fed back to coding staff to facilitate learning. The process has been reflected in the Health Board clinical coding policy. Validation forms are in place for operations and discharges to aid discussion with clinicians, which has happened on an individual basis, although there is more to do to ensure that clinicians are routinely part of validation processes. The use of Medicode™[3] to support real-time validation at the point of data entry has been explored but the system is expensive. The Health Board is waiting for the outcome of discussions about procuring a national contract for the software before proceeding. The Health Board participates in the national clinical coding audits undertaken by NWIS on an annual basis, but there is no internal coding audit programme in place. In part, this is because their team does not include a qualified clinical coding auditor.

26 Resources allocated to coding have remained consistent since our last visit, with the four staff based across four of the Health Board's community hospitals. The clinical coding supervisor oversees the staff at all four sites and is now being supported to obtain the accredited clinical coder qualification. The use of

[3] Medicode™is a piece of third-party software which supports the use of a single clinical language for health by accepting clinical terms and cross mapping to ICD10 to comply with standards. The built-in prompts and flags support users to improve accuracy and speed of the data captured.

technology has supported the team coming together more often through virtual Skype meetings, which has helped to overcome the geographical challenges associated with the Health Board. The team now code a wider range of activity including new service developments within ENT which supports more extensive use of coded information for planning purposes (as referred to in paragraph 18). In our previous report we highlighted that staff did not have access to some diagnostic systems. Whilst it was not practical for staff to have access to RADIS and Telepath as both radiology and pathology services are provided by neighbouring health boards, the Health Board could provide access to endoscopy services. This has now been resolved and coders can access endoscopy systems to support their work. Our previous review identified the need to clarify the responsibilities of coding mental health activity given that services were provided by Aneurin Bevan University Health Board at that time. Mental health services have since been repatriated back to the Health Board, and the responsibilities for coding are now correctly aligned with the Health Board's coding team.

27 In our previous review we found that the quality of medical records in the Health Board was variable. We heard mixed views as to whether there are standards in place to ensure good quality record keeping with medical staff reporting that they were not aware of any. There is no Medical Records Manager within the Health Board, which means responsibility for the quality of records is unclear. The most recent NWIS accuracy review notes that the quality of some of the physical case notes continues to cause problems for the clinical coders, and recommendations made previously by NWIS to improve the quality of the records have not been implemented. Our previous review identified no formal training for medical staff on record keeping or wider staff groups such as ward clerks. However, no work has been undertaken since our previous review to help secure improvements with the quality of medical records. There are Health Board standards for medical records, but no forum is in place to discuss and improve the quality of medical records, and no audits have been undertaken since our previous work to assess the quality of medical records.

28 Due to the geographical spread of the Health Board, multiple records are an issue. Separate medical records are created for each community hospital that a patient may be treated at within Powys. For most patients, local hospital care will be provided in one hospital, however, there will be a proportion of patients where multiple records may apply. These records are not amalgamated which may impact on the quality of coding as well as patient safety and quality of care, as relevant previous medical history may be omitted if it is contained in a sperate medical record. Patients continue to have separate records for each hospital within which they may receive treatment, although a new module on the Health Board's patient administration system has started to help standardise medical record numbers. The new module is also helping to improve tracking of medical records so their location at any given time is known. This should enable medical records to be located and transferred to the relevant hospital site to support the implementation of a single patient record, rather than creating multiple records.

Recommendations still outstanding

29 In undertaking this work, we have made one additional recommendation. This is set out in Exhibit 4. The Health Board needs to continue to make progress in addressing our previous recommendations.

Exhibit 4: new recommendations

2019 Recommendations
Clinical Coding Workload
R1 Arrange for responsibility for coding of Breconshire War Memorial Hospital activity to be rotated regularly amongst the coders to ensure exposure, expertise and knowledge are shared.

30 The outstanding recommendations are set out in Exhibit 5.

Exhibit 5: recommendations still outstanding

2014 recommendations not yet complete
Profile of Clinical Coding
R1 Raise the profile and awareness of clinical coding across the Health Board. This should include: a) providing briefing material for Board members on clinical coding and the implications of poor coded data on management information; b) providing training on the role of medical staff in the clinical coding process, particularly focusing on general practitioners; and c) increasing the visibility of a clinical coder at Brecon hospital.
Clinical Coding Accuracy
R2 Ensure processes are in place to routinely validate and review the accuracy of coding. This should include: b) engaging clinicians in the validation of coded data; c) exploring the potential to adopt the Medicode system; d) working with the national clinical coding audit lead to develop a local programme of coding audit; and e) updating the clinical coding policy to ensure that validation and audit processes are documented.

2014 recommendations not yet complete
Medical Records
R4 Improve the quality of medical records across the Health Board. This should include: a) raising the importance of good quality medical records throughout the Health Board, including all visiting medical staff; b) putting arrangements in place to reduce the number of multiple patient records; c) improving compliance with the medical records tracking system; d) improving engagement between medical records and clinical coding; and e) adopting and implementing standards for medical records across the Health Board, supported by a programme of medical records audits.

Source: Wales Audit Office.

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 6: Assessment of progress

Recommendation	Status	Target date for implementation	Summary of progress
Profile of Clinical Coding R1 Raise the profile and awareness of clinical coding across the Health Board. This should include:			
a. providing briefing material for Board members on clinical coding and the implications of poor coded data on management information;	**In progress**	Not specified by the Health Board	In our 2014 report, we found that the profile of clinical coding at Board level was low. There had been no papers to the Board over the previous two years relating to clinical coding. Our more recent work has identified that although there have been no specific papers relating to clinical coding, the Performance Dashboard now includes clinical coding performance (see R1d). The Health Board, however, needs to consider how it briefs board members on coded data and its uses, as six out of eight respondents to our survey said they would like more information on clinical coding and the extent to which it affects the quality of key performance information.
b. providing training on the role of medical staff in the clinical coding process, particularly focusing on general practitioners;	**Overdue**	Not specified by the Health Board	The Health Board has provided limited training on the role of medical staff in the clinical coding process, particularly focusing on general practioners. The reason for this is because the Health Board feels that because medical staff are not required to be part of the clinical coding process they therefore do not require training. Good practice, however, indicates that clinical engagement is the single most valuable resource to a coding department, as it is the information provided by medical staff in the patient's records that provides the basis for coding. The medical staff need to understand the work of the coders, and the importance of capturing information to support the coding process. This could be beneficial to improving the quality and accuracy of coding data being produced and would also support the coders in their activities.

Recommendation	Status	Target date for implementation	Summary of progress
Profile of Clinical Coding R1 Raise the profile and awareness of clinical coding across the Health Board. This should include:			
c. increasing the visibility of a clinical coder at Brecon Hospital;	**In Progress**	Not specified by the Health Board	Previously, there were no coders based at Breconshire War Memorial Hospital, despite it being one of the Health Board's main sites. A coder now attends Brecon Hospital at least monthly. However, the Health Board may wish to reflect on whether this is sufficient. Brecon Hospital has the greatest level of activity across the Health Board, due in the main to the surgical activity that is undertaken at this site. Additionally, it tends to be the same coder who visits Brecon to code this activity, and whilst we recognise the travel issues it may be prudent to share the workload amongst the team to ensure the expertise and knowledge are shared across all the coders.
d. reporting coding performance as part of integrated performance reporting; and	**Implemented**	Not specified by the Health Board	Previously, the Integrated Performance Report did not include the Health Board's performance in relation to the Welsh Government target for coding completeness. This has now improved. Coding performance is now more visible within the Health Board, with coding completeness and accuracy now part of the Performance Dashboard which is reported to the Board. The Health Board also has a range of Information Governance Performance Indicators which are reported to the Information Management, Technology and Governance Committee which is a sub-committee of the Board. The Health Board is also monitoring the coding performance of provider organisations, which is positive both from a financial perspective but also around quality and safety implications.
e. improving reporting lines for issues relating to clinical coding through to the Board.	**Implemented**	Not specified by the Health Board	Clinical coding is now the responsibility of the Director of Finance, through the Head of Information, and the Information and Data Quality Manager. This is a change from the previous arrangement where clinical coding was the operational responsibility of the Interim Director of Planning. The Director of Finance sees the potential in coding and has actively been using coding in discussions with provider organisations which have been discussed at Board.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Accuracy R2 Ensure processes are in place to routinely validate and review the accuracy of coding. This should include:			
a. introducing routine validation checks which include feedback to the team;	**Implemented**	Not specified by the Health Board	The Health Board has improved its validation processes, by using CHKS[4] monthly monitoring reports to look for common coding issues. Validation check forms have also been completed for coders to use when they need to query information with clinicians and coding error reports are produced which are fed back to the whole team. In addition, the Health Board uses the validation processes carried out by NWIS in the form of validation at source system (VASS) errors which are produced monthly to investigate and amend errors.
b. engaging clinicians in the validation of coded data;	**Overdue**	Not specified by the Health Board	The Health Board has introduced validation check forms to facilitate discussions with clinicians around operation notes and discharges, and the coding team have highlighted some individual conversations with consultants where validation queries have taken place. This is positive; however, we found little evidence of routine engagement of clinicians in validation of coded data.
c. exploring the potential to adopt the Medicode system;	**In progress**	Not specified by the Health Board	The use of Medicode™ to support real-time validation at the point of data entry has been explored but the system is expensive and there are currently discussions on moving the procurement of this to a national contract. Therefore, the Health Board is waiting for a decision to be made on this before proceeding. The electronic encoder system Medicode would have inbuilt validation as well as inbuilt guidance on coding classification rules which prompt users to comply with national coding standards such as external cause codes and morphology codes at the point of data entry.

[4] CHKS is a hospital benchmarking service which provides tools to ensure accuracy checks on coded data.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Accuracy R2 Ensure processes are in place to routinely validate and review the accuracy of coding. This should include:			
d. working with the national clinical coding audit lead to develop a local programme of coding audit; and	**Overdue**	Not specified by the Health Board	The NWIS audits have identified that performance has been good, with performance above the Welsh average. But the NWIS audits are only undertaken once a year using a relatively small sample of activity, and there still remains a need for a local programme of coding audit to be in place. This is hampered, however, by the lack of a qualified clinical coding auditor within the team, although clinical coding audit resources could be shared by neighbouring health boards.
e. updating the clinical coding policy to ensure that validation and audit processes are documented.	**In progress**	Not specified by the Health Board	The coding policy has been updated and contains information on quality assurance and system validation. However, this information could be more detailed, for instance, it does not mention the use of CHKS by the Health Board.
Clinical Coding Resources R3 Review the allocation of staff resources, work programmes and improve team working. This should include:			
a. providing support to the Clinical Coding Supervisor to undertake the accredited clinical coder qualification as stated in the job description;	**Implemented**	Not specified by the Health Board	Resources allocated to coding have remained consistent since our last visit. The staffing levels have remained unchanged with four coders in post. However, the coding supervisor is being supported to undertake the accredited clinical coder qualification, which is positive and peer support has been provided. NWIS are also providing support to the Health Board. A mentor has been assigned and they meet monthly. This is positive and demonstrates the commitment to supporting the supervisor to obtain the qualification.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Resources R3 Review the allocation of staff resources, work programmes and improve team working. This should include:			
b. rebalancing the clinical coding workload across the team to allow the supervisor to undertake the required supervisory duties;	**Implemented**	Not specified by the Health Board	The supervisor has taken steps to redistribute her workload by dedicating specific time to her coding workload and then to her supervisory role and enable a more effective balance of time between coding and the required supervisory duties.
c. encouraging whole team meetings to bring together all coding staff more regularly;	**Implemented**	Not specified by the Health Board	The coders continue to be located in different sites across the Health Board and bringing them together can be a drain on resources, given the geographical distance some of them would need to travel. However, Skype has recently been introduced to support virtual team working which has been a positive step and is helping to overcome the rurality issues in place.
d. exploring the potential to extend the range of activity that is coded, such as outpatient consultations;	**Implemented**	Not specified by the Health Board	The Health Board has taken the opportunity to expand its coding activities, to include new clinics such as the nurse led ENT and is now coding more specialities than in 2014. They are also coding outpatient procedures and outpatient diagnosis in some areas. They also code GP performing procedures and nurse led specialities.
e. providing the clinical coding staff with access to the endoscopy information system; and	**Implemented**	Not specified by the Health Board	Issues with access to endoscopy have been resolved and the Head of Information meets regularly with business managers and senior patient services staff to discuss any operational issues which are affecting access to records (both paper and electronic) by coders.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Resources R3 Review the allocation of staff resources, work programmes and improve team working. This should include:			
f. clarifying the responsibility for coding mental health activity to ensure that current arrangements are in line with contract agreements with Aneurin Bevan University Health Board.	**Superseded**	Not specified by the Health Board	Since our previous work, mental health services have been repatriated back to the Health Board, which means that the responsibilities for coding the activity are now correctly aligned with the Health Board's coding team. This recommendation is therefore no longer relevant.
Medical Records R4 Improve the quality of medical records across the Health Board. This should include:			
a. raising the importance of good quality medical records throughout the Health Board, including all visiting medical staff;	**In progress**	Not specified by the Health Board	In our 2014 report, we reported that the quality of medical records within the Health Board was variable. We heard mixed views as to whether standards were in place to ensure good quality record keeping. Since our review, there appears to be no change to this picture and we are unaware of any work to raise the standards of medical records.

Recommendation	Status	Target date for implementation	Summary of progress
Medical Records R4 Improve the quality of medical records across the Health Board. This should include:			
b. putting arrangements in place to reduce the number of multiple patient records;	**In progress**	Not specified by the Health Board	The Health Board currently still has issues with multiple volumes of casenotes across the Health Board sites. This affects coding because it is difficult to see the totality of a patient's care in one place. The Health Board has recently started work implementing a new module of the Welsh Patient Administration System (WPAS). This module (intelligence tracking) will enable the standardisation of casenote numbering, which the Health Board hopes will be the first step in addressing multiple casenotes. The module will also support casenote tracking to support staff in being able to locate casenotes.
c. improving compliance with the medical records tracking system;	**In progress**	Not specified by the Health Board	In August 2018, a new module of the patient administration system (intelligence tracking) was launched, the aim being to enable tracking of medical records across all the Health Board hospital sites and also to standardise numbering of medical records across the Health Board. A sub group has been established to focus on the implementation of this project.
d. improving engagement between medical records and clinical coding; and	**In progress**	Not specified by the Health Board	The Health Board has established an information champions group which is supported by the Head of Information and is currently working on implementation of the 'intelligence tracking' module. However, there is no evidence of improved engagement between medical records and clinical coding which focusses on the content and quality of health records.

Recommendation	Status	Target date for implementation	Summary of progress
Medical Records R4 Improve the quality of medical records across the Health Board. This should include:			
e. adopting and implementing standards for medical records across the Health Board, supported by a programme of medical record audits.	**Overdue**	Not specified by the Health Board	There is no evidence of any progress against this recommendation. There is no medical records forum and no evidence of medical record audits.

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 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	1	6	1	5
Satisfied	4	34	6	40
Neither satisfied nor dissatisfied	3	46	1	46
Dissatisfied	–	10	–	4
Completely dissatisfied	–	–	–	1
Total	**8**	**96**	**20**	**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	2	26
Some awareness	6	50
Limited awareness	–	17
No awareness	–	3
Total	**8**	**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	–	8	6	77
No	7	84	2	19
Total	**7**	**92**	**8**	**96**

Exhibit 10: Additional comments provided by respondents from the Health Board

- Clinical coding is reported into Information Governance Committee and we have assurance on performance in some areas – via the Commissioning Assurance Framework which is generally good. If there is underperformance in our provider or commissioned services, we consider and investigate whether the issue relates to clinical coding errors to eliminate it as a possibility, but we have honest discussions with Directors and Independent members about what the data is telling us. I would find it helpful to better understand clinical coding and the extent to which it affects the quality of information.
- The nature of our organisation means that clinical coding in other organisations from whom we commission services is important, including the sharing of information on service quality and effectiveness. The investment made in systems such as CHKS helps enormously to compare one organisation to another helping to identify both issues and opportunities.

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	Arrange for responsibility for coding of Breconshire War Memorial Hospital activity to be rotated regularly amongst the coders to ensure exposure, expertise and knowledge are shared.	To share knowledge and experience amongst the team	Yes	Yes	Formal request to transport for notes to be delivered from BWM to Ystradgynlais coder on weekly basis. Coder from Llanidloes to be based in BWM a minimum of one day every two months but in addition on an adhoc basis when the need arises. Coder based in Bronllys as main coder for BWM will attend on regular basis when notes need to remain on site. Routine collection of notes from BWM to Bronllys already in existence. This ensures that all three coders regularly code BMW activity.	April 2019	Michelle Williams (Head of Information)

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