Clinical Coding

Final Internal Audit Report

August 2024

Swansea Bay University Health Board

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

To review the structures, processes and plans in place for timely and accurate clinical coding, to ensure targets are met.

Overview

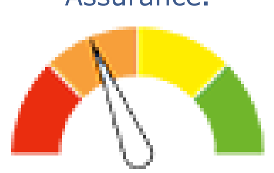
We have issued **limited assurance** on this area.

The is a clinical coding department with staff split across three hospital sites. There are a number of vacancies and recruitment is impacted by external factors. As such there is insufficient resource to meet Welsh Government targets. The issues are generally understood within the department and actions have commenced, however there is no formal improvement plan and we have noted limited reporting and escalation of the challenges faced outside of the department.

The key issues that require management action are:

- Fully assessing the resource requirement for clinical coding;
- Ensuring up to date guidance for clinicians and tracking areas with poor quality information;
- Developing a formal improvement plan for clinical coding; and
- Ensuring clinical coding is formally reported within both the Digital Directorate and at Board Committee level.

Report Opinion

		Trend
Limited Assurance. 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	None

Assurance summary[1]

	Objectives	Assurance
1	There are appropriate resources available for clinical coding.	Limited
2	There is an appropriate structure to ensure accurate and timely coding.	Reasonable.
3	There is a process for identifying areas for improvement.	Limited
4	An appropriate reporting framework is in place.	Limited

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Resourcing	1	Design	High
2	Documentation and Guidance	2	Design	Medium
3	Service Improvement Plan	3	Design	Medium
4	Reporting	4	Design	High

1. Introduction

1.1 Clinical coding is a hospital or practice administration function that involves translating written clinical statements into coded data. A clinical coder will interpret information about an aspect of patient care and assign standardised codes using a classification system.

1.2 Clinical coding helps to efficiently manage the patient's data compared to traditional data libraries utilising piles of documented papers. Every code carries crucial information, from a patient's name to the final results of the diagnosis and this helps with monitoring changes and the creation of an action plan or forecast for possible medical emergencies in the future.

1.3 Clinical coded data is essential to the information used by NHS organisations to govern business and ensure resources are used efficiently and effectively. Coded data has a part to play in decision making and strategic plans as well as playing an important role in reporting and mortality rates.

2. Detailed Audit Findings

Objective 1: The resources required for clinical coding have been assessed and appropriate resourcing is in place.

2.1 Clinical coding plays a pivotal role in accurately translating medical diagnoses, procedures, and services into universal codes for documentation, billing, and research purposes. Therefore, ensuring sufficient resources for this function is critical to maintaining operational efficiency and data integrity for Swansea Bay University Health Board (the 'health board'). The health board's clinical activity results in a requirement to code approximately 11,000+ records per month.

2.2 The Clinical Coding Department consists of 31 members of staff; 16 part-time (11 WTE) and 15 full-time, but currently has three whole time equivalent (WTE) vacancies. The Team operates across three hospital sites (Morriston, Singleton and Neath Port Talbot).

2.3 All new clinical coders are required to undergo the Accredited Clinical Coder (ACC) accreditation process to ensure high standards and professional development. Nine members of the team have successfully obtained the qualification and there are also 12 experienced staff members who have been in place prior to the ACC accreditation being compulsory and bring valuable expertise. The ten remaining members of the team are trainees. Trainee coders start their employment as Band 3, and upon passing the ACC exam, they advance to become qualified Band 4 clinical coders.

2.4 We note that there are challenges to recruit and retain clinical coders. We were informed that qualified clinical coders are paid higher salaries in England than in Wales and that, combined with the greater ability for home and remote working across the border, has led to several qualified coders leaving roles based in Wales.

2.5 All staff members undertake refresher courses. Staff who have earned the ACC qualification do not need re-accreditation, but they must complete a 3-day

refresher course and pass an assessment every three years with the coding service at Digital Health and Care Wales (DHCW), as do the experienced staff members.

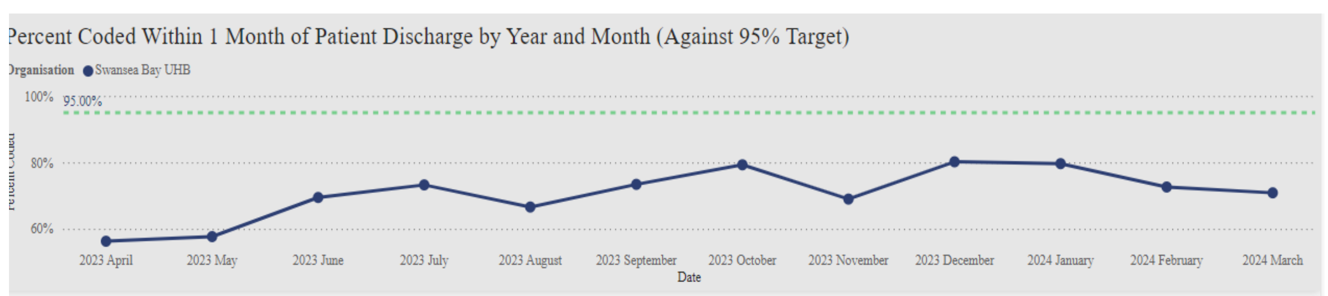
2.6 Several variables can impact the accuracy and timeliness of clinical coding. Factors such as clinicians not providing sufficient information in patient notes can prevent coders from accurately applying the relevant codes, necessitating additional communication with the clinician. Records being removed from Medical Records by clinical departments after the coding list has been produced also pose challenges due to time spent trying to relocate the files, and the complexity of case notes may require more experienced coders, thereby affecting overall workload.

2.7 In addition, staff shortages, trainee inefficiency, and an approximation of 10% sickness also affect the volume and turnaround of episodes. With the high volume of coding required, it's not possible for the coders to complete all coding by the end of the month, leading to a backlog.

2.8 Currently coders will endeavour to complete 30 coded episodes per day, however the team is unable to cover the 11,000+ monthly cases. As a result, approximately 71% of episodes are coded each month. The backlog accumulates as the remaining 29% of episodes are not addressed until the end of the year. **Matter Arising 1**

2.9 As previously noted, the department is carrying vacancies, however, there has been no full assessment to evaluate the resources needed to ensure that the organisational clinical coding demands are met which considers factors such as workload volumes, case complexity, and regulatory requirements. **Matter Arising 1**

2.10 An analysis of the Admitted Patient Care (APC) system data provided by DHCW (Clinical Coding Completeness Dashboard - Power BI) has showed that SBUHB's coding performance from April 2023 to March 2024 is below the Welsh Government Tier 1 target of 95% monthly target and currently running below the 98% target over the rolling 12-month period. We note that although the majority of other health boards in Wales also fail to meet the targets, SBUHB consistently performs at the lower end. **Matter Arising 1**



Percentage of Episodes Coded Within 1 Month of Patient Discharge

Organisation	Month & Year	Total Episodes	Episodes Coded	Percent Coded
Swansea Bay UHB	Mar 2024	12866	9119	70.88%
Swansea Bay UHB	Feb 2024	12542	9109	72.63%
Swansea Bay UHB	Jan 2024	13086	10424	79.66%
Swansea Bay UHB	Dec 2023	12316	9880	80.22%
Swansea Bay UHB	Nov 2023	13423	9261	68.99%
Swansea Bay UHB	Oct 2023	12974	10289	79.30%
Swansea Bay UHB	Sep 2023	12271	9010	73.43%
Swansea Bay UHB	Aug 2023	12561	8366	66.60%
Swansea Bay UHB	Jul 2023	12584	9219	73.26%
Swansea Bay UHB	Jun 2023	12458	8655	69.47%
Swansea Bay UHB	May 2023	12349	7125	57.70%
Swansea Bay UHB	Apr 2023	11320	6373	56.30%
Total		**150750**	**106830**	**70.87%**

(Matter Arising 1).

Conclusion:

2.11 The health board has a defined departmental structure for clinical coding, consisting of a mix of experienced staff and trainees. All team members are required to undertake regular refresher training on clinical coding. Vacancies and high sickness absence rates have resulted in team falling short of Welsh Government performance targets, contributing to the backlog of cases waiting to be coded. However there has been no full assessment of its resources to ensure it can meet the organisational clinical coding demands. Accordingly, we have provided **limited assurance** over this area.

Objective 2: There is an appropriate structure, including policies and procedures and staff engagement, within the organisation to ensure accurate and timely coding.

2.12 There is a structured process for processing of records to be coded in which Health Records play a crucial role. There is a requirement within the health board that, once clinics are completed, patient records are promptly returned. This allows the Medical Records staff to generate a daily list of episodes needing coding, which is then provided, along with the records, to the Clinical Coding Team. Urgent items are clearly marked and prioritised.

2.13 Our review of the policies, procedures, and guidelines related to clinical coding noted that, aside from the job descriptions for various roles, the only other policy document (Clinical Coding Policies and Procedures) is a 'draft' and is dated November 2015. **Matter Arising 2.**

2.14 For protocols, rules, and formats followed by the coders, the policy mandates adherence to the current International Classification of Diseases: tenth revision (ICD-10-2016) coding of episode diagnoses and OPCS 4.10 (coding of episode interventions and procedures) industry standards documents. We note the existence of an updated version, ICD-10-2019, which is available online, but has not been mandated for use in Wales.

2.15 The ICD-10 documents utilised by the coding teams are considered the primary source of guidance and are accessible to all clinicians. We note that ICD-10 is being superseded by the eleventh revision (ICD-11), which is digitally based and will necessitate substantial retraining for all staff due to the relabelling of many currently used codes. The introduction of ICD-11 is anticipated around 2026.

2.16 The ICD-10 states that it is intended for use by clinical coding staff, clinical analysts and clinicians. However, we observed that it lacks instructions or guidance for clinicians on patient note writing protocols, and there is no health board guidance for clinicians in recording patient information in a manner suitable for use by the coding team. **Matter Arising 2.**

2.17 The absence of clear guidance for clinicians on the information required by clinical coders necessitates daily follow-ups by the coders, typically via email or phone calls. There is currently no formal, documented process to record and track these requests and no standardised request form, whether electronic or hard copy, making it difficult to monitor their frequency and identify areas with persistent poor quality records. **Matter Arising 2**

2.18 Welsh Government requires 90% clinical coding accuracy within 35 days of reporting. The data quality dashboard monitors these errors, which the Clinical Coding teams need to correct weekly, and we note that the accuracy of coding undertaken is good and meets the target.

2.19 Quality checks are performed on coders undergoing ACC training by the supervisor and the trainer. Once qualified, they are considered competent coders. DHCW conducts an annual audit, randomly selecting upwards of 400 cases for review, and the results of which have been favourable, with any errors communicated to the supervisor and immediately corrected.

2.20 Once the coding is completed, it is saved into MediCode. (a software application system designed to assist healthcare professionals with medical coding). Medical coding involves converting healthcare diagnoses, procedures, medical services, and equipment into standardised codes. The information is then automatically uploaded into a data warehouse and transferred to the APC system. DHCW uses an SQL script to identify any errors by comparing the data to ICD-10 standards. Although we note that not all standards are covered due to the binary nature of the script. Any data quality errors identified by DHCW are sent back in a report and forwarded to the supervisors for further action. We note that the issues are not with the quality or accuracy of the coding, but with the time taken. Although the provision of better guidance to clinicians would likely improve both.

Conclusion:

2.21 There is a structure within the health board to identify records for coding and pass these to the Clinical Coding department. We note the that the policy is draft and there is no guidance for clinicians which contributes to the need to gain additional information. There is a process for quality assuring the coding process and we note that there is good level of accuracy in coded records. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 3: There is a process for identifying areas for improvement, including leveraging technology and plans in place to deliver these.

2.22 The Clinical Coding Department is generally aware of the issues they are facing that impact productivity and their ability to meet the requirements of the organisation, including:

- inadequate levels of staffing;
- unavailability of notes, such as those sent to clinics or secretaries, preventing timely coding;
- incomplete discharge summaries;
- lack of clear diagnoses and up-to-date comorbidities in each episode, placing the burden on coders to make decisions or query clinicians, which is time-consuming;
- consultants not responding appropriately to coders requests for more information; and
- the medical record system consisting of both paper and electronic formats, creating a vast amount of information to review and affecting productivity.

2.23 The non achievement of the Welsh Government target for clinical coding is recorded on the Digital Services Risk Register (risk number 443). This was originally scored at 9, but has recently raised to 12 with the likelihood increased from 3 to 4. We note that since the health board is not meeting the target the score for likelihood may still be low however.

2.24 Actions have been identified to address the issues impacting on clinical coding, some of which are currently underway. These actions include but are not limited to:

- increasing the amount of electronic coding available;
- updating the coding video for doctor inductions and presentations to clinicians and colleagues;
- communicating to colleagues the difficulties in coding episodes with incomplete discharge advice letter (DAL) and poorly presented notes;
- improving communication between Health Records and Clinical Coding;
- holding weekly meetings between supervisors and the coding teams; and
- conducting regular management meetings with the senior team.

2.25 However, there is no formal service improvement plan which sets out all the actions to be undertaken, resource and timescale and responsibilities. Without a formal plan in place the health board may find it hard to effectively move forward and track actions. **Matter Arising 3.**

2.26 We note that an increasing number of Health Boards are adopting a more automated approach to clinical coding. As an example, Aneurin Bevan University Health Board uses Blue Prism to code the least complex and repetitive episodes, achieving over 90% accuracy. SBUHB is currently exploring automation options with various external suppliers, although these efforts are still in the early stages.

Conclusion:

2.27 The issues impacting on timely clinical coding are understood within the department, and actions to address these are underway. The risk associated with non-compliance with the Welsh Government target is included within the risk register. We have noted that there is no formal, structured improvement plan that fully defines the actions to be taken and which allows reporting and monitoring of successful delivery of improvements. Accordingly, we have provided **limited assurance** over this objective.

Objective 4: An appropriate reporting framework is in place.

2.28 There are well-defined lines of reporting within the Clinical Coding Department, extending from supervisors through local management up to the Digital Directorate, with regular engagement at all levels.

2.29 We have been informed that informal meetings are held across the Clinical Coding management structure approximately every two to three weeks. During these meetings, the management team and supervisors provide updates on previous actions. It has been confirmed that minutes are not recorded for these meetings, consequently we were unable to determine that issues are being appropriately addressed and in a timely manner.

2.30 Responsibility for clinical coding sits within Digital Services, for which there is a monthly Digital Services Business Meeting (DSB) attended by senior management. These are formal meetings with an agenda and action log, however, our review of the DSB business noted that there was no inclusion of issues or updates related to clinical coding. Specifically there is a lack of escalation relating to the health board's monthly coding performance, which consistently fall below the Tier 1 Welsh Government target. This omission means that clinical coding concerns may not be brought to the attention of senior management and are addressed solely during the weekly meetings with supervisors and line managers. While it is possible that these issues are resolved at a lower level, there is no evidence to indicate that such resolutions are reviewed during the DSB meeting. A sustainable long-term solution is unlikely to be identified and implemented without escalation. **Matter Arising 4.**

2.31 Our review of health board committee papers also noted limited reporting in respect to clinical coding. There was an expectation that an update would be provided at the January 2024 Performance and Finance committee meeting,

however this was not reported. The lack of consistent reporting highlights a deficiency in the reporting and escalation of Clinical Coding challenges and issues to senior management and independent members. **Matter Arising 4**

Conclusion:

2.32 There is a management and reporting structure within Clinical Coding, and a Clinical Coding reports into Digital Services. However, there is a lack of reporting and escalation of clinical coding issues both within Digital Services and at Board Committee level, despite the challenges being faced by the health board in this area with performance falling consistently below Welsh Government targets. Accordingly, we have provided **limited assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Resourcing (Design)		Impact
The resource within the Clinical Coding department is not sufficient to enable the organisation to meet the Welsh Government target of 95%. At the current work rate of approximately 30 coded episodes per day by each individual, the team are only able to code approximately 71% of the 11000+ monthly cases. As previously noted, the department is carrying vacancies, however there has been no full assessment to evaluate the resources needed to ensure that the organisational clinical coding demands are met which considers factors such as workload volumes, case complexity, and regulatory requirements.		Potential risk of: • Non-compliance with WG targets.
Recommendations		**Priority**
1.1	A full assessment to evaluate the resources needed to ensure that the organisational clinical coding demands are met should be undertaken which considers factors such as workload volumes, case complexity, and regulatory requirements. This should be integrated into an improvement plan which seeks to increase efficiency within the department in order to maximise the use of clinical coders time.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1	A resource and improvement plan has been created outlining actions required over the next two financial years. The impact of this plan is shown below:	October 2024	Assistant Director of Digital Intelligence

Fin Year	Trainees (FTE)	Qualified (FTE)	Vacancies FTE	Auto-coding Training time (WTE)	Auto-coding Episodes	Total Episodes	Episodes Coded	Coding Percentage
25/26	5.8	17.7	-1.5	-1	7674	153,487	117,137	76%
26/27	5.5	19.5	-1	-0.5	18725	153,487	145,119	95%

The resource plan includes estimates on staff turnover and the move to a centralised location by 1st April 2025. It should be recognised that the only option available to manage the turnover of qualified staff due to the issues identified in the report and replacing trained coders with trainees is the introduction of an "auto-coding" product. There is a recognition that the auto-coding product will take time to train however it will increase productivity over time and is seen as a long term solution. Initial conversations and a pilot phase has been established with an external company. In order to introduce the auto-coding product there would have to be a re-banding of all the staff (as has been undertaken in Cwm Taf Morgannwg University Health Board) to change their roles from traditional coders to an audit and analysis role. The rebanding of staff will cost approximately £95k annually from year one rising to £165k by year three. A business case to support the auto-coding solution will be prepared once the initial pilot phase has been completed to take to BCAG. This will include associated financial costs. This work is anticipated to start in October 2024.

<table>
<tr><th colspan="2">Matter Arising 2: Documentation and Guidance (Design)</th><th>Impact</th></tr>
<tr><td colspan="2">We noted issues with out of date or incomplete documentation:
• The Clinical Coding Policy is a 'draft' dated November 2015;
• There is no clear guidance for clinicians on the information required by clinical coders. This contributes to the need for daily follow-ups by the coders requesting additional information; and
• There is currently no formal, documented process to record and track information requests and no standardised request form, whether electronic or hard copy, making it difficult to monitor their frequency and identify areas with persistent poor quality records.</td><td>Potential risk of:
• Non-compliance with WG targets.</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>2.1</td><td>Documentation should be reviewed and updated to ensure the following are in place:
• An up to date Clinical Coding Policy;
• Guidance for clinicians on the information needed for coding;
• A standard template for additional information requests; and
• A record of information requests.</td><td>Medium</td></tr>
</table>

Agreed Management Action		Target Date	Responsible Officer
2.1	The current draft clinical coding policies and procedures document will be updated and signed off by the clinical coding senior team before being distributed across the department via the teams channel. The Coding presentation video for junior doctors will be updated and presented at future junior doctor induction meetings. Bookmarks sheet showing clinicians terms and symbols to use/not to use within the notes that can be used by coders for coding to be re-distributed. Coding Intranet page to be created – containing information on DALs and the importance of completing them.	September 2024 August 2024 October 2024 January 2025	Assistant Director of Digital Intelligence

Matter Arising 3: Service Improvement Plan (Design)			Impact
The non achievement of the Welsh Government target for clinical coding is recorded on the Digital Services Risk Register. Actions have been identified to address the issues impacting on clinical coding, some of which are currently underway. However, there is no formal service improvement plan which sets out all the actions to be undertaken, resource and timescale and responsibilities. Without a formal plan in place the health board may find it hard to effectively move forward and track actions.			Potential risk of: • Non compliance with WG targets
Recommendations			**Priority**
3.1	A formal service improvement plan should be developed, and progress against this monitored. The plan should include actions to address all the issues and include responsible officers, targeted deadlines and an identification of resources required.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Appointment of a Band 6 Service Improvement lead responsible for creation and enabling of a service improvement plan following recruitment freeze. An action plan has been created based on the findings of the audit with an action log and regular meetings to take place around its implementation. The clinical coding risk on the Digital Risk Register is to be increased to a score of 16 and escalated to the Health Board Risk Register. It is anticipated that the Centralisation of the Health Records and Coding Departments into one single unit will help with communication across departments. The options around auto-coding are currently being assessed with an implementation expected to begin if funding allows in April 2025.		November 2024 August 2024 September 2024 April 2025	Assistant Director of Digital Intelligence

Matter Arising 4: Reporting (Operation)	Impact
Clinical Coding sits within Digital Services for which there is a monthly Digital Services Business Meeting (DSB) attended by senior management. These are formal meetings with an agenda and action log, however, our review of the DSB business noted that there was no inclusion of issues or updates related to clinical coding, specifically the monthly coding targets, which consistently fall below the Tier 1 Welsh Government target. This omission means that clinical coding concerns may not be brought to the attention of senior management and are addressed solely during the weekly meetings with supervisors and line managers. While it is possible that these issues are resolved at a lower level, there is no evidence to indicate that such resolutions are reviewed during the DSB meeting. A sustainable long-term solution is unlikely to be identified and implemented without escalation. Our review of health board committee papers noted that there is limited documentation available in respect to Clinical Coding. There was an expectation that the Performance and Finance committee paper (January 2024) would convey the status of Clinical Coding, unfortunately this was not reported. The lack of consistent reporting suggests a potential deficiency in the reporting of Clinical Coding to senior management regarding clinical coding performance.	Potential risk of: • Senior management not aware of the issues in clinical coding. • Issues are escalated.

Recommendations		Priority
4.1	Clinical coding should be regularly reported to the DSB.	**High**
4.2	Clinical Coding challenges should be escalated at Board and Committee level.	

Agreed Management Action		Target Date	Responsible Officer
4.1 4.2	Coding performance KPIs including monthly coding target performance will be presented at the Business meeting every 3 months as part of the Digital Intelligence presentation. Health Board risks are approved at the business meeting via the risk paper which includes progress against the action plan – coding targets not being met is to be escalated from a digital risk to a Health Board risk and will also be reported on at business meeting through that route. Coding updates against the action plan and targets will be added to the Digital Leadership Group Highlight Report paper which gets presented to Health Board leads every three months.	July 2024 September 2024 September 2024	Assistant Director of Digital Intelligence

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

Rating	Definition
Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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