DATA QUALITY REPORT 2013/14

INFORMATICS DIRECTORATE

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INTRODUCTION

The purpose of this report is to provide the Health Board with an Annual Report summarising the Data Quality improvement work undertaken in 2013-14. This is in line with the requirements of the ministerial letter (EH/ML/007/08) which mandated that all NHS Trusts and Health Boards provide an annual data quality report to the Board.

Background & Context

The NHS in Wales uses information as an integral part of its approach to delivering health services. Operationally, NHS bodies are highly reliant on electronic information systems to support a range of key activities including:

- patient administration, scheduling and booking;

- diagnostic processes, ordering tests, requesting and viewing results;

- joining primary and secondary care pathways, sharing potentially lifesaving critical patient information;

- effective financial management and enable management of productivity;

- providing the best patient care based on accurate clinical and demographic details; and

- identification and achievement of clinical and business outcomes.

Information used to support management and healthcare delivery is only reliable if the quality of the underpinning data is sound. NHS Wales Informatics Service (NWIS) identifies six core elements that affect data quality which are timeliness, completeness, validity, consistency, precision and accuracy. While it is rarely possible to ensure data is 100 percent correct, 100 percent of the time, it is critical that health bodies have appropriate and effective data quality arrangements in place to minimise clinical risk, support effective operational delivery and management, and to underpin performance management and Health Board assurance processes.

The availability of relevant, complete, accurate and timely data is crucial. For the information to have value and to allow meaningful comparison and benchmarking, it is essential that the data is consistent and complies with national standards. Health Boards are assessed and judged on the quality and accuracy of the data they submit to national reporting bodies.

ABMU HB must also be able to assure themselves that local performance against the standards monitored by the Standards for Health Services in Wales in particular Standard 19 are being met. The standard requires organisations and services to support and facilitate patient care and service delivery by:

a) Developing and using safe and secure information systems in accordance with legislation and within a robust governance framework;
b) Having processes to operate and manage information and data effectively and to maintain business continuity;
c) Ensuring data quality is robust and timely;
d) Using information to review, assess and improve services; and
e) Sharing information with relevant partners using protocols when necessary.

It is essential to ensure that all of the data used is of sufficient quality to enable the Board to be confident in its assessment. The Data Protection Act 1998 also sets the legal requirement for data users; ensuring that personal data is kept accurate and up to date is one of its fundamental principles.

Scope

In order to provide assurance to the Health Board this report will cover the following areas:

- Performance against the National Data Quality indicators and how this compares with other Health Boards in Wales
- The new Governance arrangements for data quality issues
- Local data quality improvement work including training and awareness
- Clinical Coding performance, including local audit and improvement work
- Challenges for 2014 onwards

From a primary care perspective, arrangements for data quality support and governance remain with the NHS Wales Informatics Service (NWIS). The Health Board is actively engaging with NWIS in order to clarify the processes to ensure optimum levels of primary care data quality. During 2013/14 NWIS undertook the national re-procurement of the General Medical Practice Data Quality System AUDIT+ and established a Governance Advisory Group with the aim of ensuring the appropriate governance arrangements are in place for primary care data. ABMU will continue to provide support in relation to developments in primary care data and information quality.

| 1.	PERFORMANCE AGAINST NATIONAL DATA QUALITY INDICATORS

The national Data Quality performance indicators cover the following datasets:

- Admitted Patient Care (APC) dataset
- Outpatient dataset
- Outpatient Referral dataset
- Emergency Department dataset (EDDS)

The indicators measure both the **validity** and **consistency** of the data and are assessed on a monthly basis as part of the data submission process. The *validity* indicators ensure that all data has the appropriate data item recorded for each record, whereas the *consistency* indicators measure related data items which are able to be compared to one another. For such related data items, the presence of a specific value in one field can restrict the value(s) that can be recorded in another. For example, where the primary diagnosis of a record is a maternity event, the gender attached to the record must be female.

1.1 Admitted Patient Care (APC) dataset

The chart below shows the **APC data validity** performance for ABMU, which again this year is 100%, meeting all 31 checks. ***Appendix 1*** details the performance by Health Board for the full year 2013-14 for these indicators.
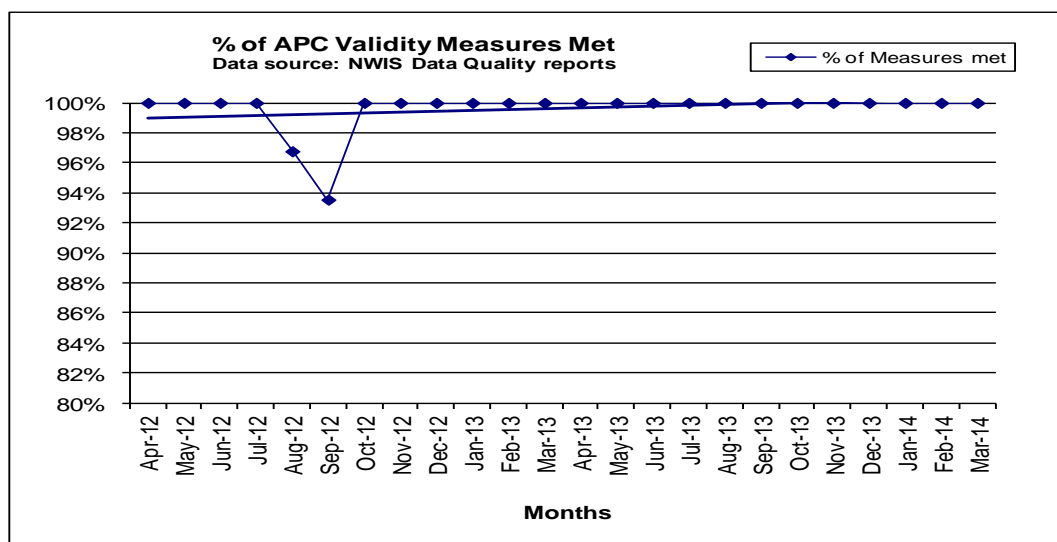
ABMU performance for **APC data consistency** also remains at 100% as shown in the chart below. These indicators measure 27 sets of data items that are related which are able to be compared to one another. ***Appendix 2*** details the performance by Health Board for the full year 2013-14.

% of APC Consistency Measures Met
Data source: NWIS Data Quality reports

Performance 100% - APC consistency
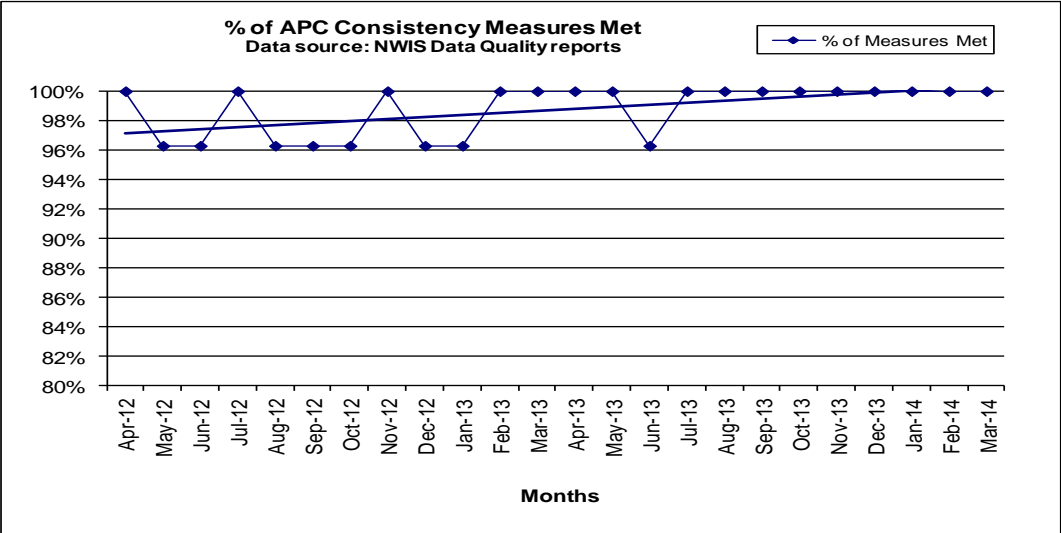
ABMU Health Board achieved all the targets for both the accuracy and consistency of data in the APC dataset, the only other NHS organisation in Wales achieving this was Velindre NHS Trust.

1.2 Outpatient Dataset – Outpatient Activity

The chart below shows the performance for the **Outpatient Activity Validity** Dataset at 87%, achieving 20 out of 23 indicators in March 2014. The 23 Outpatient activity data validity indicators measure the accuracy of the data submitted for key outpatient data items. *Appendix 3* details the performance for the year by Health Board for 2013-14 for this indicator.

% of Outpatient Validity Measures Met
Data source: NWIS Data Quality reports

Performance 87% - Outpatient validity
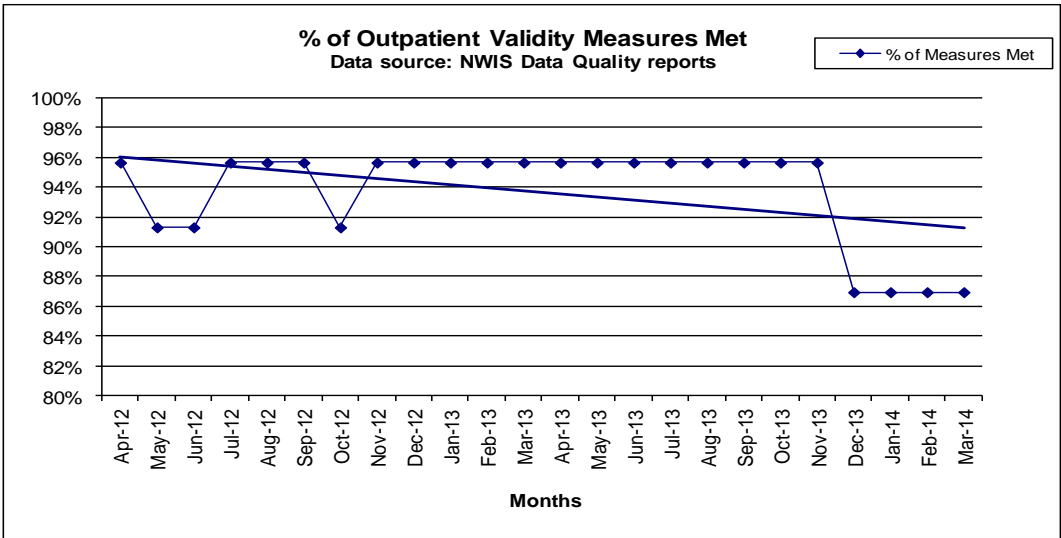
Performance throughout most of 2013-14 was consistently high each month at 96%, with just one validity indicator not being achieved which was the **Referrer Code** standard. In November 2013 however, following the implementation of Myrddin in Bridgend/NPT, a further 2 indicators were lost due to technical issues, which were for **Referring Organisation Code** and **Source of Referral**. The technical issue relating to *Referring Organisation Code* was addressed as part of a data re-submission, resulting in us achieving 21 of the 23 indicators for the year as shown in **Appendix 3**. The *Source of Referral* technical issue is currently being resolved by the Information Development team, which will then restore our 96% performance.

Further work required – Outpatient validity indicators

The area where further work is required relates to **Referrer Code**, with performance for the year at 90.9% (98% target). There are two main reasons why ABMU are not hitting the target for this indicator:-

- No national file of external consultants currently available on the Myrddin system.
  Action: The NWIS Myrddin team have given assurance that there is renewed focus to ensure that national reference data files are available and up to date.
- Use of generic codes for GP's and non Consultant Health Professionals such as Allied Health Professionals.
  Action: The use of these generic codes needs investigating and this has been scheduled into the Data Quality work programme for 2014-15.

A new set of **Outpatient Activity data consistency** measures were introduced in November 2013. The chart below shows ABMU performance at 86%, achieving 12 of the 14 sets of data items, *Appendix 4* details the performance by Health Board for the full year 2013-14 submission for these indicators.

Performance 86% - Outpatient consistency
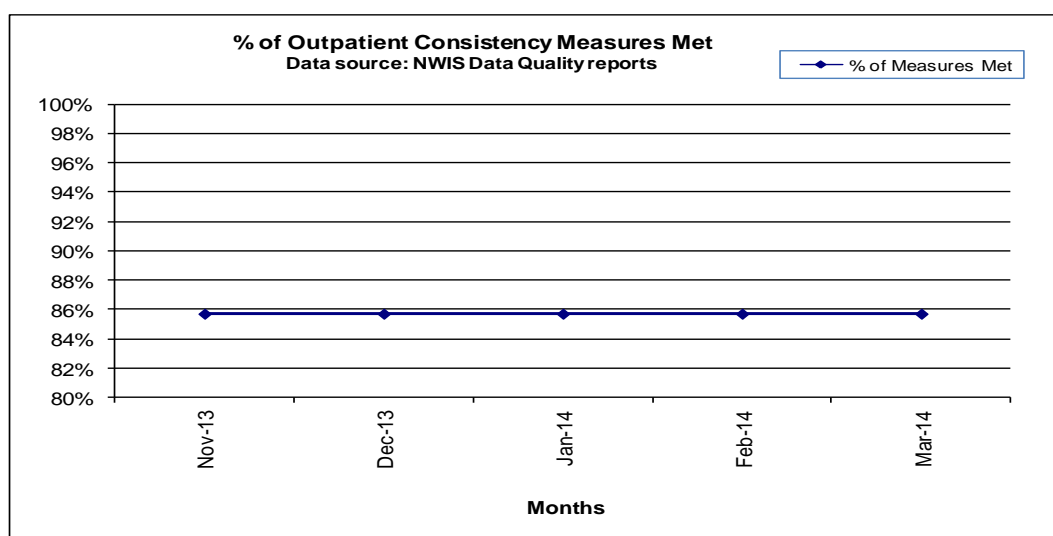
The 2 sets of indicators ABMU did not meet are for *Source of Referral vs. Referring Organisation* 94.3% (98% target) and *Referrer Code vs. Source of Referral* 75.1% (98% target), both of which are linked to the above validity issues.

1.3 Outpatient Dataset - Outpatient referrals

All-Wales Performance for this indicator can be found at *Appendix 5*. ABMU met 14 of the 15 **Outpatient referral data validity** targets each month, an improvement on last year's position. The NHS number standard was resolved when the Enterprise Master Patient Index (EMPI) came into use. The areas where further work is required to achieve the target relate to the **Referrer code** (linked to the issue above).

% of Outpatient Referral Validity Measures Met
Data Source: NWIS Data Quality Reports

Performance 93% - Outpatient referral validity
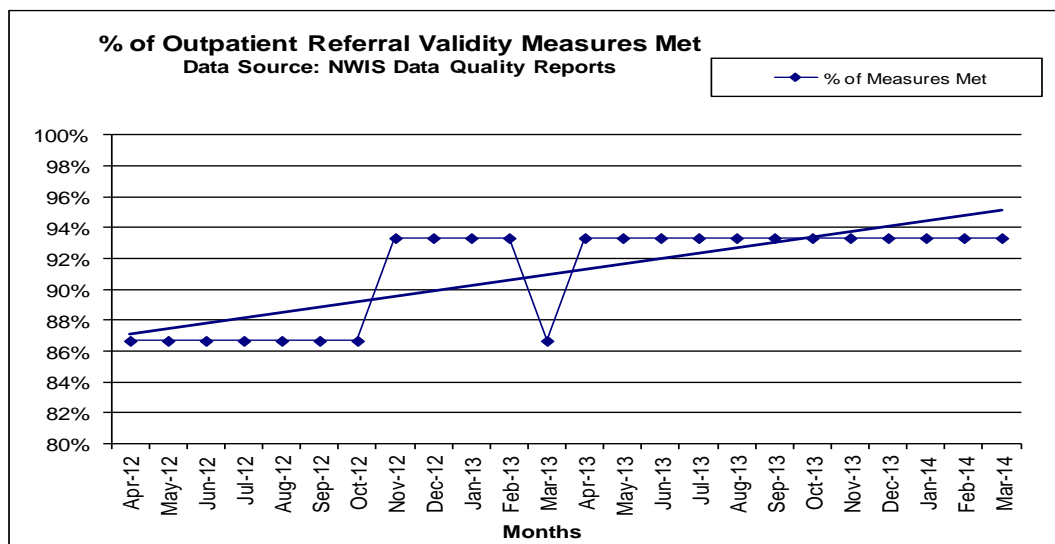
1.4 Emergency Department Dataset submission (EDDS)

The EDDS data indicators now measure the accuracy and consistency of data for major and minor sites for key Emergency Department data items. New indicators were introduced in October 2013, which were consistency indicators for Major Units and both validity and consistency indicators for minor A&E Units & MIU's. *The Data Quality team have made significant progress towards ABMU achieving all of the above targets.*

A full review of all EDDS indicators not met was carried out in February 2014, the results of which were published in a report prepared by the team in March and resolutions are being worked through with a view to implementing required changes for the August 2014 submission.

1.4.1. Major Unit sites (Morriston & Princess of Wales Hospitals)

Performance for **EDDS data validity** for both *major* Emergency Departments was 100% with all 29 indicators being met as shown in the chart below. *Appendix 6* details the performance by Health Board for the full year 2013-14 for these indicators.

% of EDDS Validity Measures Met for Major A&E Units
Data source: NWIS Data Quality reports

Performance 100% - major units (validity)
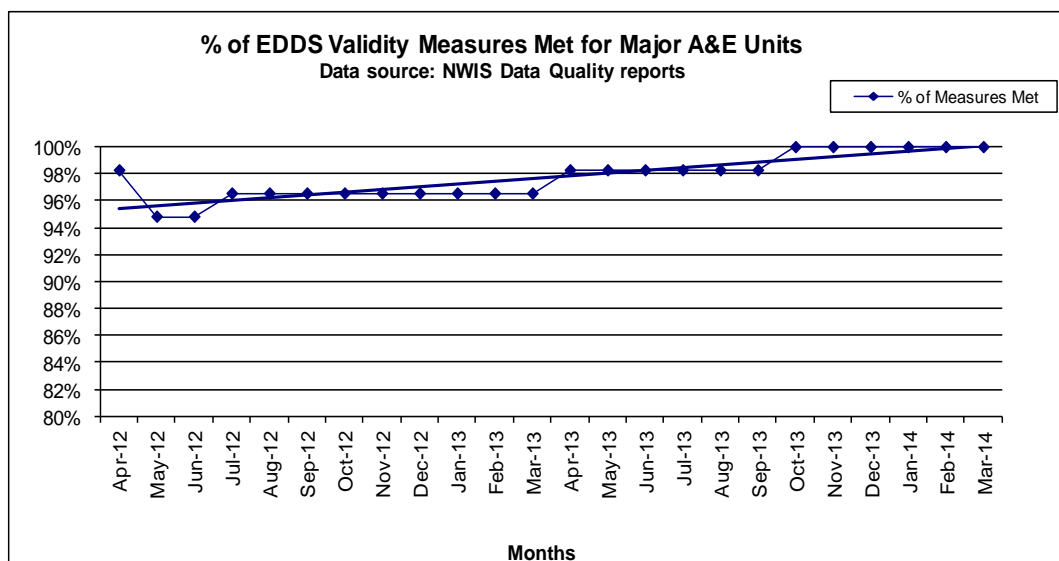
The chart below shows ABMU performance at 93% for the new **EDDS data consistency** targets introduced in October 2013 (21 checks in total measured at end of March position). Morriston Hospital missed 3 of the

targets, 2 of which are data mapping issues that relate to the data item *Attendance Category,* which have now been addressed. The third target missed related to Attendance Group vs. Outcome of Attendance and this is being closely monitored by the team to ensure this target is not missed in future.

Appendix 7 details the performance by Health Board for the full year 2013-14 for these indicators.

Performance 93% - major units (consistency)
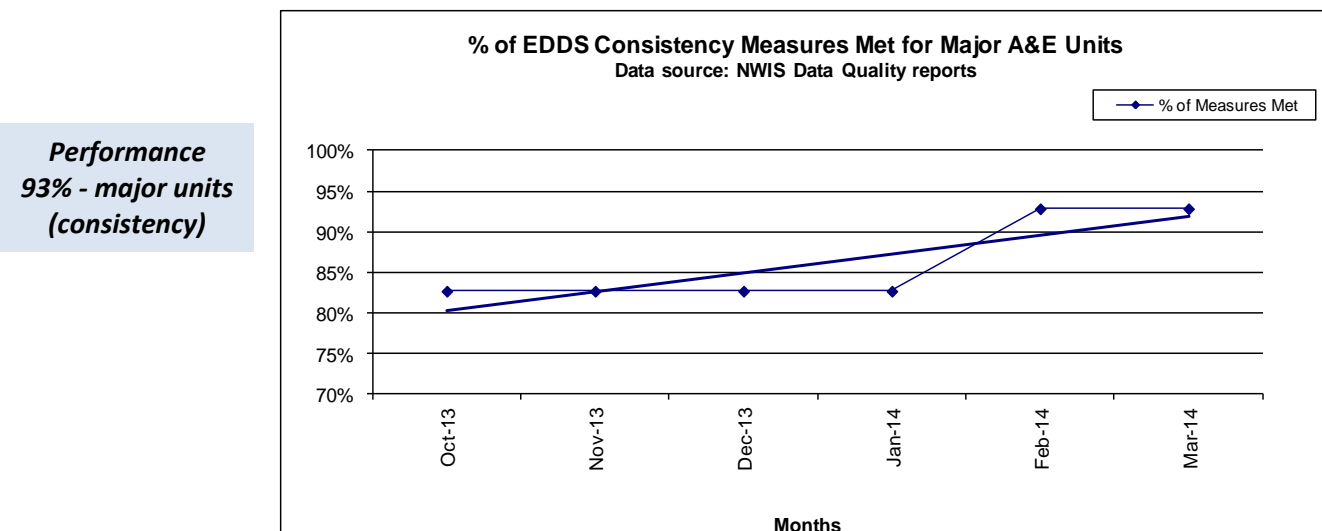
1.4.2.   Minor Unit sites (Singleton & Neath Port Talbot Hospitals)

ABMU met 26 of the 28 new **EDDS data validity** indicators which were introduced in October 2013, for MIUs and Minor A&E Units, achieving performance of 97%. Singleton Hospital missed 2 targets at end of March position which were for GP Practice Code 90.7 (98% target) and NHS Number Status Indicator 92.1 (98% target), both of which have now been resolved.

Appendix 8 details the performance by Health Board for the full year 2013-14 for these indicators.

Performance 97% - minor units (validity)
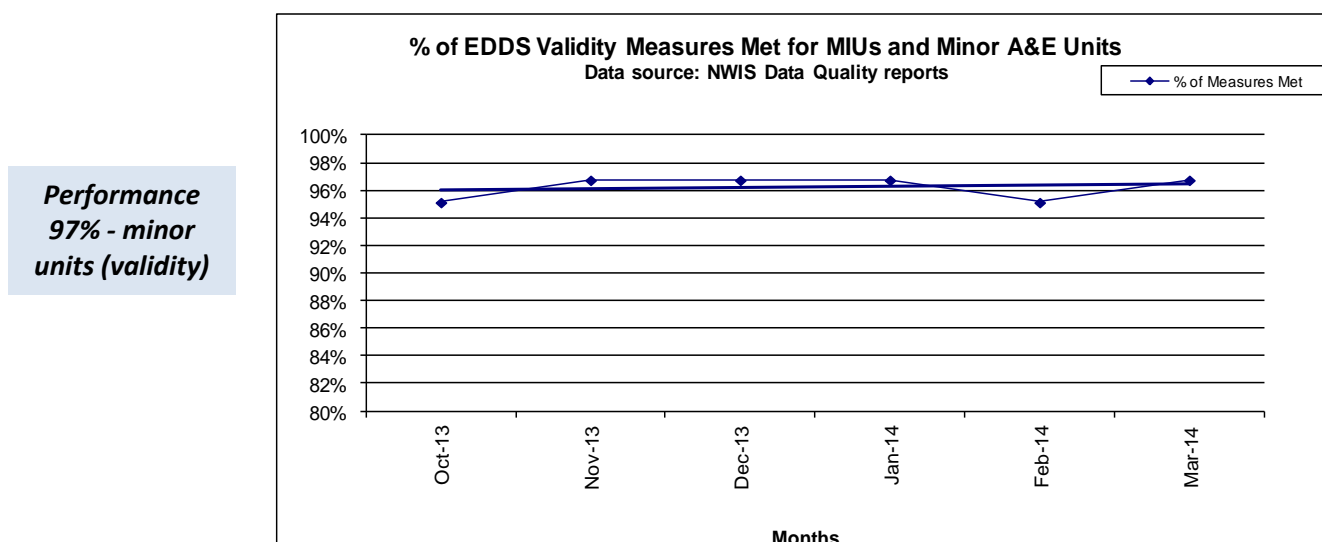
Performance is achieved at 98% for the new **EDDS data consistency** targets for MIUs and Minor A&E Units (21 checks in total measured at end of March position). One target was missed for Singleton Hospital for *Referrer Code vs. Referring Organisation code*, which related to a data mapping issue and has now been resolved. *Appendix 9* details the performance by Health Board for the full year 2013-14 for these indicators.

Performance 98% - minor units (consistency)
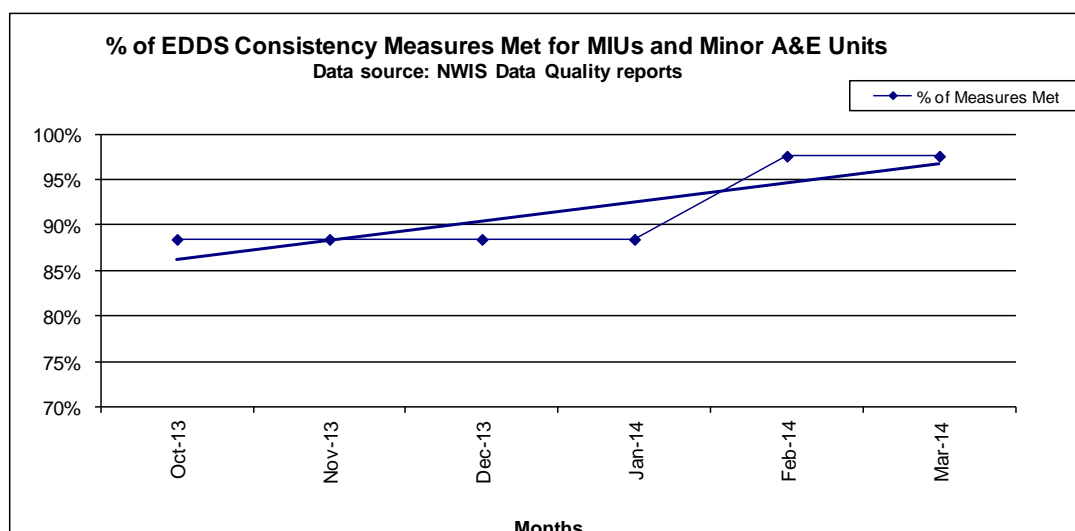
% of EDDS Consistency Measures Met for MIUs and Minor A&E Units
Data source: NWIS Data Quality reports

◆ % of Measures Met

(Line chart showing % of Measures Met from Oct-13 to Mar-14, with y-axis from 70% to 100%. The diamond-marked series stays around 88-89% from Oct-13 through Jan-14, then rises to about 97-98% in Feb-14 and Mar-14. A straight trend line rises steadily from about 86% in Oct-13 to about 97% in Mar-14.)

X-axis: Oct-13, Nov-13, Dec-13, Jan-14, Feb-14, Mar-14

Months

2. GOVERNANCE

Informatics Governance Committee (IGC)

The purpose of the Informatics Governance Committee (IGC) is to provide:

Assurance to the Quality & Safety Committee that:

a) Informatics developments are planned and delivered across the whole Health Board according to organisational goals and priorities;
b) Improving the availability, consistency, accuracy, validity and quality of clinical information is at the core of Informatics developments;
c) Informatics services contribute and support the delivery of safe, effective patient care
d) There is clear, consistent strategic direction, strong leadership and transparent lines of accountability for Informatics;
e) Risks are actively identified and robustly managed within the Informatics Directorate

Advice to the Quality & Safety Committee by:

f) Providing evidence based and timely advice to the Committee to assist it in discharging its functions and meeting its responsibilities for the quality and integrity, safety and security and appropriate access and use of information to support the Health Board's provision of high quality healthcare.
g) Recommending policies and procedures relating to informatics and information governance to the relevant Board/Committee

Since September 2013, the newly formed IGC which is chaired by the Non-Officer Member for Informatics has met on a quarterly basis. The IGC terms of reference includes the following responsibility for data quality assurance:

- The **integrity of data and information** is protected, ensuring valid, accurate, complete and timely data and information is available to support decision making across the organisation;

In order to discharge its duty in this area the Committee has received and reviewed the following evidence throughout 2013-14:

- The **Data Quality Policy** underwent an annual review in 2013 and has been updated to reflect the recent changes to the Informatics Governance structure and recommendations from the 2012/13 WAO review of data quality.

- The 2012/13 annual Data Quality Report was reviewed and recommended to the Q&S Committee by the IGC in 2013
- The IGC received the following audits in relation to data quality:
  - **Internal Audit – Data Quality: Referral to Treatment times June 2013**
    The objective of the review was to ensure that the information used to manage RTT and reported to the Board and Welsh Government is complete, reliable, timely and clear. The review made 4 recommendations which included clarifying definitions of some of the RTT rules resulting in 'clock' adjustments; accurate recording of referral receipt dates in Myrddin and accurate recording of mutually agreed appointment offers. The review had limited scope in that it only sampled patient pathways within 2 specialties of a sample Locality. A further follow up audit was carried out in March 2014, to review progress against the actions.
- The national Data Quality Key Performance Indicators have been reported at every meeting to ensure any dips in performance are investigated and resolved.
- Clinical Coding performance and issues are also reported quarterly
- QA of the corporate self assessment submission for Standards for Health Services in Wales – Standard 19 ICT and Standard 20 – Records Management
- The IGC has recommended that a data quality performance framework is devised to ensure the Health Boards performance data can be assured. This work will be further developed in 2014/15.
- The IGC provides a bi-annual key issues report to the Q&S committee.

3. DATA QUALITY IMPROVEMENT WORK 2013–14

The Data Quality team have faced a challenging year and this has limited the capacity to make progress in all required areas, but despite this, improvements have been made in the following areas:

3.1 Performance against national indicators – A full review of Emergency Department data indicators not met was carried out in February 2014, and recommendations have been put in place in order to achieve all validity and consistency checks. As mentioned in section 1.4 of the report, this improvement in performance will be reflected now in the 2014-15 performance reports.

3.2. Single PAS - Whilst ABMU saw the implementation of a single PAS in 2013-14 and has made real inroads towards real-time Admission, Discharge and Transfer (ADT) information on the Swansea sites, the effects of the complex architecture linking the different systems has made this an extremely challenging year for the Data Quality Team.

A significant amount of the team's resources were invested both prior to and following the implementation of Myrddin at Princess of Wales and Neath Port Talbot Hospitals in November 2013. This was paramount in order to assist with the data migration and to deal with the issues that evolved after implementation.

In addition, the complex technical architecture required to get information from the ABMU Clinical Portal into the Myrddin PAS has won an award for the Health Board's ICT Development Team. The team has been recognised by software integration company NDL, who chose ABMU as the winner in the 2014 Best Integration/Automation Project category, due to the *'high level of complexity and scale involved in the project'*. The key aim was to combine the referral pathway management elements of Myrddin and the ABMU Portal, and critically for patient records to be updated and synchronised in a live environment, ensuring the very latest data is always available on both systems. The solution has also ensured that ward staff do not double-enter information into two systems, which has saved time and reduced typographical errors in order to maintain data quality.

3.3 Monitoring -The automated Data Validation Database which enables the Data Quality team to address data inaccuracies and inconsistencies and provide feedback and advice to users, has been expanded further to include this year's new checks, both national and local. Since ABMU has implemented a single PAS system in November 2013, the Database now provides a consistent way of addressing data quality issues across all sites. This function also enables the Clinical Coding team to report any missed activity on the patient administration systems to the Data Quality Team for correction on a daily basis. This ensures all activity is captured and coded in order to accurately reflect the Health Board's performance.

3.4 Feedback and reporting - The team has continued to feedback to both users and Directorates on a day to day basis as part of the validation processes in place. Following the implementation of Myrddin into Princess of Wales and Neath Port Talbot Hospitals in November 2013, a significant amount of feedback to users was necessary, in order to maintain the data flow between systems. The team also worked directly with areas during this time, for example Princess of Wales Urology Unit, as they were experiencing difficulties with the transition.

3.5 Audits – As part of the work carried out to resolve the issue with the Out-patient follow-up not booked waiting lists and finding electronic solutions to validate the lists, an audit was undertaken to ensure correct outcomes were being recorded on the system. This exercise highlighted issues and actions have now been put in place to help ensure rules are being applied consistency across all sites.

3.6 Training & Awareness
- **Clinical informatics sessions** are being delivered on a number of key development programmes targeting both managerial and clinical staff, such as the Managing to Deliver programme and the Post Grad Medical Education Training Programme.
- **Training and education programmes** are held in conjunction with Corporate training, Health Records and clinical system training colleagues to ensure all new and existing staff have a full understanding of the importance of assuring the quality of data recorded in patient systems.
- **Consultant training** - As part of the training provided to Consultant colleagues, a half day Informatics session is provided giving a full overview of Informatics services and strategy in ABMU HB. A significant element of this session focuses on the use of clinical information and specifically the Consultant Information Portal which supports consultant appraisal and job planning processes.
- **Less formal sessions** are also held as part of the work undertaken by the Data Quality Team, which have included individual staff being targeted for further training and/or support and an awareness session held with Patient Pathway Co-ordinators to explain the implications of inaccurate data being recorded on the bed states.
- **Data Quality Team** – Throughout 2013-14, the staff based at Princess of Wales Hospital attended training on various Myrddin courses in readiness for the implementation in November 2013. All staff attended eMPI Inspector training.

3.7 Action Plan 2014-15
The Data Quality Team will focus on the following areas throughout 2014-15, which form part of their work improvement plan.
- **Staffing review** - a review of resources within the Data Quality Team is to be carried out, in order to assess areas of responsibility and capacity. Additional resources will enable the team to address more issues recorded on the work improvement plan.
- **Launch of Clinical Portal (Swansea sites) July 2014** – assist with data migration, support hospital wards on the week of the launch and deal with issues that evolve following implementation.
- **Performance: national data indicators** – improve performance further by investigating and addressing issues with the Referrer code indicator in the Outpatient Activity and Outpatient Referrals datasets.

This will involve working with Directorate staff to clarify processes. New additional checks are also being introduced for Critical Care, which will need to be assessed.

- **Data flow issues** – reduce the number of issues with the data feed from the Clinical Portal to Myrddin, as these have the potential to affect the next stage of patient care. This will involve working with the development team and feeding back to users.
- **Out-patient Follow-up Not Booked waiting lists** –This involves validation of lists in order to take pressure off services, implementing the new proposed process and ensure there is consistency of RTT rules across sites. Three members of staff have joined the data quality team for 6 months in order to carry out this validation work.
- **Bed adjustments** – undertake a review with the Project/Development team to discuss a more streamlined way to record bed adjustments, for example closures due to infection etc.
- **Data Quality Validation Tool** – a full review of errors feeding in to the database needs to be carried out in order to take into account national and local service changes.
- **Reference data cleansing** – A review to be carried out to ensure all reference data, including Consultants; Ward locations etc are valid and up to date.   This is necessary following the implementation of a single PAS and the launch of the new Clinical Portal July 2014.
- The Head of Information will continue to provide support in relation to developments in **primary care data and information quality.**

In addition, a **data quality performance framework** will be developed to ensure the Health Board's performance data can be assured. In order to provide confidence at Board level that the data and information used within the organisation is of a high enough standard to be used to inform decision making and monitor performance, the Board has requested that a Data Assurance Framework be developed. The Informatics Directorate has been working with Internal Audit to explore how this can be taken forward and the initial focus has been on the development of a data quality assessment matrix for the key (tier 1) performance measures for the Health Board. This work includes researching methods utilised by other NHS Trusts in England; redeveloping definitions to be applicable to the Health Board and assessing the suitability of the chosen method by testing one of the key performance indicators in conjunction with service leads in order to fully test the process.

What this work will **not** do is assess whether the indicator itself is actually measuring the right thing. For example, the appropriateness of using the average to measure lengths of stay in hospital which would be significantly skewed by the numbers of short and long stay patients.

It is anticipated that national work on the development of the Outcomes Framework and the Improvement Framework will be taking forward the development of more appropriate meaningful measures for process and outcomes within a healthcare system.

3.8 Risks
Carrying out the above improvement work will be dependent on the following:

- The NWIS Myrddin team providing national reference data for external Consultants.
- The NWIS Myrddin team to action requests for change relating to the data flow issues.
- Available resources within the Project/Development team to review the bed adjustment process.
- Capacity within the Data Quality Team to cleanse reference data.
- Unexpected technical issues that affect quality of data.

4. CLINICAL CODING

4.1 Clinical Coding Performance

Within the Health Board, clinical coding is used for a variety of purposes, not least the ability to report on key efficiency and productivity indicators such as short stay surgery performance and quality and safety indicators such as condition specific mortality rates and risk adjusted mortality rates.

A timely view of these indicators is key to the effective monitoring and management of standards of performance. In addition, clinical coded data is used to baseline and model service improvement ideas as part of the Changing for the Better Programme.

New Clinical Coding targets were introduced across NHS Wales in April 2013 which form part of the Welsh Government Tier 1 Performance and Delivery Targets as detailed below:

- **95% in month completeness** across all admission types (elective and emergency) and all patient classes (inpatient and day case) within 3 months of discharge.
- **98% rolling 12 month completeness** across all admission types (elective and emergency) and all patent classes (inpatient and day case) within 3 months of discharge.

ABMU Health Board has achieved the Year End target for 2013/2014, which was submitted to NHS Wales Informatics Service (NWIS) on 4th July 2014. The overall 12 month completeness was 98.66% across the Health Board. It should be noted that all months exceeded the 98% completeness target for each individual month apart from March 2014 at 97.98%; with only 2,706 of the 202,013 episodes left uncoded. Table 1 provides a breakdown of the 2013/14 Year End position.

Table 1: Clinical Coding Completeness 2013/2014

FINANCIAL YEAR 2012 / 2013	Coded Episodes	Uncoded Episodes	Total Episodes	Completeness (%)
ABMU TOTALS	199307	2706	202013	98.66%
April	16683	110	16793	99.34%
May	17347	128	17475	99.27%
June	16191	194	16385	98.82%
July	18379	156	18535	99.16%
August	16305	219	16524	98.67%
September	16824	212	17036	98.76%
October	17921	242	18163	98.67%
November	16442	258	16700	98.46%
December	15113	281	15394	98.17%
January	16424	261	16685	98.44%
February	14886	299	15185	98.03%
March	16792	346	17138	97.98%

Coding Performance 2014/2015

The table below shows the current coding performance for 2014/2015 activity, with April 2014 completeness at 83.31% at 12 wks; which falls well below the required target of 95% for July's month end. The lack of coding performance is a direct consequence of ensuring optimum coding completeness levels for year end; every effort is being made by the coding teams to address the current backlog situation.

Table 2: Clinical Coding Completeness 2014/2015

FINANCIAL YEAR 2014/2015	Coded Episodes	Uncoded Episodes	Total Episodes	Completeness (%)
ABMU TOTALS	**31183**	**33195**	**64378**	**48.44%**
April	13908	2786	16694	83.31%
May	8927	7936	16863	52.94%
June	6098	10964	17062	35.74%
July	2250	11509	13759	16.35%

Depth of Coding and Signs & Symptoms Coding

The following depth and signs and symptoms coding has been extracted from the CHKS Benchmarking System showing:-

- An increase on depth of coding from 4.1 during 2012/13, to 4.3 over the last financial year
- Signs and Symptoms coding has decreased from 11.23% in 2012/13 to 11.08% in 2013/14, which in turn should result in more accurate quality information for reporting purposes.

4.2 Service developments

- **Training & Development of Coding Staff**

  Throughout 2013-14 the coding staff have continued to update their professional development as detailed below:-

  - Attendance at Renal & Urology, General Surgery, General Medical and ENT speciality workshops over the last 12 months to keep abreast of new classification changes.
  - Clinicians are scheduled to provide talks to the coding staff in respect of Head and Neck Cancers and associated surgery to further develop their knowledge for coding purposes.
  - Trainee coders have attended Foundation Training, and continue to receive mentorship and training in support of attaining the National Accredited Clinical Coding (ACC) qualification.
  - 46% of the department are now ACC qualified**. This qualification is designed to ensure the Coding profession achieve the very highest level of professional standards in order to ensure the Health Board's clinical data is as accurate and complete as possible**. 5 members of staff have attained double distinction awards in the ACC qualification, with our latest achiever quite possibly being one of the Top 10 achievers across the country.
  - The Clinical Coding department approach to training and mentoring of new staff is something they are very proud of and this commitment was recognised, when Ann Wathan the Coding Supervisor at NPTH won the Chairman's "Outstanding Mentor" Award in November 2013.

Figure 1 - Ann Wathan receiving her award from the Chairman

- **Clinician Engagement**

  Throughout 2013- 14 the coding teams have been proactively engaging with Clinical Teams to improve the accuracy and quality of coding, and the following service improvements have been implemented:-

- A Heart Failure proforma has been designed in conjunction with Dr Geraint Jenkins to incorporate the national heart failure diagnosis, which have been cross-matched to ICD-10 codes. This proforma is now being placed within the case note record to provide clearer concise information at the point of coding. (See Appendix 10)
- Meetings have been held with clinical teams to review OPCS procedure codes for operations, to assist with improving the current operation documentation provided at the point of coding.
- Coding supervisors have been working closely with the Electronic Discharge Communication Project and Clinical teams to develop the most common Top 20 diagnosis codes for different specialities such as Cardiology, Ophthalmology and General Medicine. This will be used to provide drop down menus in order to speed up data entry when completing discharge summaries.
- At the above meetings, coding supervisors also take the opportunity to update clinical staff on coding rules and national standards.

- **Clinical Audit Lead Coder**
  - The Coding Service will shortly be appointing to the post of Clinical Coding Audit Lead for ABMU Health Board, who will be responsible for implementing a robust programme of internal audits to ensure the quality and accuracy of coding is maintained. This post is only open to existing suitably qualified staff.

4.3 Clinical Coding Audits

Over the last 12 months a number of audits have been carried out across the Health Board which include:

- **Surgical Mortality Audit – Princess of Wales Hospital - July 2013**
  50 case notes were audited with Surgical Clinicians, to undertake a full mortality review and assess the accuracy of information recorded. The findings showed that 94% of primary diagnosis and 96% of the primary procedures were coded accurately. The absence of complete and timely discharge summaries continues to hinder the coding process, as often a definitive diagnosis is not clear within the patient's case notes. All errors found were amended by the coding supervisor, and the audit results were presented to the Clinical Outcome Steering Group.
- **Advancing Quality Care Alliance (AQuA) – Princess of Wales Hospital – November 2013**
  The Coding Management team were interviewed as part of the AQuA review process, and provided an overview of the current working practices across the Coding Service, and highlighted the daily challenges for coders due to the lack of timely discharge summaries, clinical record keeping, and duplicate case notes.

  It was recommended that a process should be implemented to make it easier for coders to discuss queries regarding clinical recording with consultants, and also the requirement to have consultant coding champions. Action plans have been developed to address all of the associated recommendations.
- **External Clinical Coding Review – Wales Audit Office (WAO)**
  The WAO were commissioned to undertake a full Clinical Coding review across ABMU in February/ March 2014, with assistance provided from the NWIS Clinical Classifications Team who undertook the audit of clinical coding accuracy. The full WAO report has yet to be received; however, feedback has been provided from NWIS colleagues on coding accuracy:
  - A sample of 90 case notes per clinical coding team across ABMU HB were examined to review the accuracy and condition of the patient health record. The following specialities were reviewed: - General Medicine, General Surgery and Trauma & Orthopaedics (30 records per speciality) for activity undertaken from April to September 2013.

- The overall findings of the audit demonstrate a very competent standard of coding accuracy and sound commitment from the clinical coding teams to achieve accurate and complete clinical coding data. The accuracy rate across ABMU HB was 89.53% for primary diagnosis, with 86.75% of secondary diagnoses correct. 90.65% of primary procedures and 90.92% of secondary procedures were correct. The required standard is 90% for primary diagnosis and procedure, and 80% for secondary diagnosis and procedure.

ABMU Overall Coding Accuracy

ABMU Coding Accuracy	Total codes	Correct codes assigned	Overall %
Primary Diagnosis	**363**	**325**	**89.53%**
Secondary Diagnosis	**1011**	**877**	**86.75%**
Primary Procedure	**246**	**223**	**90.65%**
Secondary Procedure	**584**	**531**	**90.92%**

Appendix 11 details the speciality specific breakdowns per hospital site.

- The report highlighted many examples of good practice, stating that all staff demonstrated a good grasp of national clinical coding rules and standards, the high proportion of ACC qualified staff in post and the importance the organisation placed on regular internal audits as part of the PDR process which has encouraged a culture where the importance of accuracy is well understood.

- The audit did however, raise concerns as to the accuracy of Trauma & Orthopaedic coding, with the auditors highlighting the challenges facing the coders due to the lack of clinical information, discharge summaries or definitive diagnosis provided within the case note record. It was recommended that all staff should attend a Trauma & Orthopaedic workshop to improve the accuracy of coding along with the need for coders to engage more with clinicians to discuss coding queries. The Coding Manager is in the process of arranging additional Trauma & Orthopaedic training for all staff.

- The report also recommended that immediate efforts must be made to ensure that all staff across ABMU who have responsibility for clinical case notes are aware of the need for good practice regarding their use. In particular, attention should be drawn the Royal College of Surgeons 'Standards for Clinical Records'.

- **Individual Audits –** In order to provide evidence of a coder's performance for their personal development reviews, a sample of the clinical coder's work is reviewed for accuracy by the Coding Supervisory Staff on an annual basis. In the last 12 months 33 staff members (out of a total of 37) were audited and the findings showed an overall accuracy rate of 95% for primary diagnosis, and 96% for primary procedure coding.
  Any coding errors identified as part of the above audits, are amended in accordance with the audit findings and lessons learned /recommendations relayed to the individual coding staff.
- **Ward Audits –** The Coding Supervisory team have assisted Health Records colleagues to undertake ward based audits across several ABMU wards to review casenote management compliance. Standard Operating Procedures have also been developed for ward staff, and the coding supervisors will assist with the cascade training to improve case note management processes. A full report on the findings of this audit have been shared with service/ward managers across the Health Board.

4.4 Awareness raising
Throughout the year there have been numerous presentations carried out for clinical staff by the Coding Management Team to continue to raise awareness of clinical coding. These included attendance at the

Palliative Multi Professional Education session, Medical Directorate Mandatory Training sessions, and presenting as part of the Clinical and Senior Nurse/Managers Development forums.

These sessions always prove to be very interactive and evoke numerous questions from consultants and junior doctors, especially when highlighting the very strict rules which apply to what can and cannot be coded by the Clinical coders. These sessions highlighted the need for further information to be provided for junior doctors to support better clinical record keeping, and a clinical coding bookmark is distributed to all junior doctors at induction which details what the coders and can and cannot code. Further work is underway with the Post Graduate managers in order expand the training and understanding provided to junior doctors on Clinical Coding.

4.5 Challenges for 2014-15

The Coding Service are pleased to report that the Year End 2013/14 Tier 1 Performance targets have been achieved, in spite of significant challenges over the past 12 months. The level of performance does not however, provide timely enough clinical coding completeness to support in-month, more real-time monitoring of performance indicators which are dependent on clinical coding or enable clinical coding to be used more effectively to support operational processes. There are a number of issues outlined below which continue to hinder the ability to further improve the timeliness of clinical coding:

- **Discharge Summaries -** Despite completion of discharge summaries being one of the six priority quality indicators for the Health Board, performance remains disappointing with the overall provision of a full discharge summary completed and being sent to the GP currently at 41.56% across ABMU HB. The absence of a complete and timely **discharge summary** continues to hinder the coding process, as often a definitive diagnosis is not provided within the patient's case notes.
- **Case note Management** – There are a number of issues in relation to the management of the physical case note which impact the coding service, these include:
  o Case notes entering the department with insufficient or no clinical documentation contained within the folder. This situation is caused by poor record management procedures at ward level, along with temporary/multiple folders not being amalgamated within the acute case note folder at discharge.
  o Case notes not being tracked by staff outside of the Health Records Departments, resulting in manual searches for case notes at ward and department level.
  o The condition of the case note also causes problems for the coding staff, as information is poorly collated, with documentation often out of chronological order and entries not dated.
  - The implementation of 'closed volumes' will assist in improving this situation with case notes. The Health Records Department are currently liaising with Departments to roll out the use of closed volumes.
  - The eventual solution to the inherent problems with the reliance on the paper clinical record is, of course, the availability of a full electronic clinical record for our patients. The Informatics IMTP (3 year plan) sets out the projects required to achieve paper-lite working in clinical areas such as the roll-out and continual enhancement of the ABMU clinical portal to support admitted patient flow and the innovative paper-lite ideas being taken forward for the new Outpatients department at Morriston Hospital.

- **Coding Resource & Capacity** – Clinical coding is a productivity service and as outlined above, has robust reporting and monitoring processes in place to manage performance at both a service and individual coder level. Despite the significant improvements achieved during 2013/14 and the further improvements being taken forward during 2014/15 (Full details are available in the Clinical Coding Improvement Plan attached as Appendix 12), it is clear from the calculations undertaken by the Clinical Coding service that additional coding resources are required, along with a step change in the quality and completeness of clinical documentation particularly discharge summaries, if, the timeliness of clinical coding is to improve to the level required to support more real-time clinical information reporting.

  The Health Board is aware of the additional investment required within the Coding Service to achieve more timely and complete clinical information to attain the Tier 1 Performance Targets. Significant investment has been provided to other Welsh Health Boards on a recurrent basis along with short term

investment at some, to address their year-end backlogs, with contract coders being employed to work over the weekends. These contract coders are often Welsh Health Board coders who are able to earn significantly higher rates from these contracts than is paid via overtime rates. Four ABMU Coders are currently employed as contract coders for other Health Boards, which has resulted in less staff working overtime to address our coding backlogs.

Discussions have taken place at an All Wales level, regarding the lucrative contract coder market, and the knock on effects across the clinical coding service, and options are to be explored on the feasibility of setting up a "Coding Bank" for provision of coding resources.

ALL WALES APC DATA VALIDITY STANDARDS PERFORMANCE MONITORING REPORT 2013-14

Data Item	DATA VALIDITY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB	Aneurin Bevan University LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf University LHB	Hywel Dda University LHB	Powys Teaching LHB	Velindre NHS Trust
APC submission received by the 17th	-	-	✓	✓	✓	✓	✓	✓	✓	✓
Number of Records Loaded	-	1079982	201054	207591	216749	154268	97332	119263	4879	78846
Administrative Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Admission Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Admission Method	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultant Code	98%	✓	✓	97.7	✓	97.1	97.9	✓	96.7	✓
Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decision to Admit Date	98%	✓	✓	✓	93.8	✓	✓	✓	✓	✓
Discharge Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Discharge Destination	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Discharge Method	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Duration of Elective Wait	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode Start Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethnic Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
HRG Code[†††]	95%									
Intended Management	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Last Episode in Spell Indicator	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Legal Status	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Local Health Board of Residence	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Main Specialty (consultant)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	93.6	✓	✓	93.7	71.2	✓	53.1	✓	✓
Patient Classification	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode[††††]	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Principal Diagnosis[†]	95%	✓	✓	✓	✓	94.7	✓	✓	✓	✓
Principal Procedure Code[†/††]	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Principal Procedure Date	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrer Code	98%	✓	✓	✓	97.8	✓	✓	✓	97.2	✓
Registered GP Practice Code	98%	82.3	✓	✓	68.3	97.2	✓	0.9	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Admission	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Specialty of Treatment Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓

ALL WALES APC DATA CONSISTENCY STANDARDS PERFORMANCE MONITORING REPORT 2013-14

Data Consistency Check	DATA CONSISTENCY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB	Aneurin Bevan University LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf University LHB	Hywel Dda University LHB	Powys Teaching LHB	Velindre NHS Trust
Admission Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Admission Method vs. Duration of Elective Wait*	98%	✓	✓	✓	93.2	✓	✓	✓	✓	✓
Admission Method vs. Intended Management	98%	96.8	✓	✓	84.3	✓	✓	✓	✓	✓
Admission Method vs. Patient Classification	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Admission Method vs. Source of Admission*	98%	✓	✓	✓	92.1	96.8	✓	✓	✓	✓
Consultant Code vs. Main Specialty (consultant)	98%	✓	✓	✓	97.2	95.9	90.3	✓	✓	✓
Discharge Method vs. Discharge Date & Date of Birth [i.e. Age]*	98%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Discharge Method vs. Discharge Destination*	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Discharge Method vs. Specialty (of Treatment)*	98%	43.9	✓	✓	5.9	75.0	0.0	n/a	n/a	n/a
Episode End Date vs. Admission Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode End Date vs. Discharge Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode End Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode End Date vs. Episode Start Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode Start Date vs. Admission Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode Start Date vs. Discharge Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Episode Start Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
HRG Code vs. Sex[†]*	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Last Episode in Spell vs. Episode End Date & Discharge Date*	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Legal Status vs. Specialty (of Treatment)***	98%	89.3	✓	87.3	68.1	✓	✓	✓	0	n/a
Patient Classification vs. Discharge Date & Admission Date [i.e. Length of Stay]*	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode vs. Local Health Board of Residence**	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Diagnosis Code vs. Admission Date & Birth Date [i.e. Age][†]*	95%	✓	n/a	✓	91.7	✓	n/a	✓	n/a	n/a
Primary Diagnosis Code vs. Sex[†]*	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Procedure Code vs. Sex[†]*	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Procedure Date vs. Episode Start Date & Episode End Date	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrer Code vs. Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Specialty (of Treatment) vs. Sex*	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓

ALL-WALES OUTPATIENT ACTIVITY DATA VALIDITY PERFORMANCE MONITORING REPORT 2013-14

Data Item	DATA VALIDITY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB	Aneurin Bevan University LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf University LHB	Hywel Dda University LHB	Powys Teaching LHB	Velindre NHS Trust
OP submission received by the 20th	-	-	✔	✔	✔	✔	✔	✔	✔	✔
Number of Records Loaded	-	3986806	928621	511656	733174	636882	593373	464678	38625	79797
Administrative Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attended or Did Not Attend	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Code of Registered GP Practice	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultant Code					☐		☐	☐		☐
Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Patient Referral			☐	☐		☐	☐	☐	☐	☐
Location Type Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Main Specialty (Consultant)	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Staff Type Seeing Patient	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	✓	✓	✓	✓	76.5	✓	✓	✓	✓
Organisation Code (LHB Area of Residence)	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcome of Attendance	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode of Usual Address††	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Procedure Code†	98%	✓	✓	✓	90.1	✓	✓	✓	✓	✓
Priority Type (New Patients)	95%	✓	✓	✓	92.5	✓	✓	✓	✓	✓
Referrer Code	98%	95.2	90.9	96.2	95.4	✓	97.4	94.2	97.8	✓
Referring Organisation Code	98%	94.8	✓	75.9	93.6	✓	✓	96.2	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Referral: Outpatients	98%	✓	92.8	✓	✓	✓	✓	✓	✓	✓
Treatment Function Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓

Referrer code	ABMU cannot hit this target due to: • no national file of external consultants currently available on Myrddin. (Other Myrddin sites such as Aneurin Bevan, also have this issue) As an organisation providing tertiary services, ABMU have a high number of external consultants referring to them. • Use of generic codes for GP's and non Consultant Health Professionals such as Allied Health Professionals.	NWIS Myrddin team have given assurance that there is renewed focus on working to provide this data to allow selection of named external consultants. Use of generic codes needs investigating – work has been scheduled into Data Quality work programme 2014-15.
Source of Referral	Technical issue.	Currently being resolved.

ALL-WALES OUTPATIENT ACTIVITY DATA CONSISTENCY PERFORMANCE MONITORING REPORT 2013-14

Data Item	DATA CONSISTENCY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB	Aneurin Bevan University LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf University LHB	Hywel Dda University LHB	Powys Teaching LHB	Velindre NHS Trust
Number of Records Loaded	-	3986806	928621	511656	733174	636882	593373	464678	38625	79797
Clinical Referral Date vs Attendance Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Birth vs Attendance Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date Of Patient Referral vs Attendance Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Birth vs Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Patient Referral vs Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Birth vs Date of Patient Referral	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultant Code vs Main Specialty (Consultant)	98%	97.5	✓	✓	✓	97.2	89.2	✓	✓	✓
Attendance Category vs Priority Type (New Patients)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Location Type Code vs Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode of Usual Address vs Organisation Code (LHB Area of Residence)	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Procedure Code (OPCS) vs Sex	95%	✓	✓	✓	✓	✓	✓	✓	✓	n/a
Referrer Code vs Referring Organisation Code	98%	✓	✓	✓	✓	97.3	✓	✓	97.8	✓
Referrer Code vs Source of Referral: Outpatients	98%	84.0	74.6	92.8	86.0	67.3	96.3	94.8	✓	✓
Source of Referral: Outpatients vs Referring Organisation Code	98%	92.8	94.3	✓	✓	67.9	✓	✓	✓	✓

Referrer code vs.Source of Referral	Linked to above issues – See Section 1.2 of report and Appendix 3.
Source of Referral vs. Referring Organisation Code	

ALL-WALES OUTPATIENT REFERRALS DATA VALIDITY PERFORMANCE MONITORING REPORT 2013-14

Data Item	DATA VALIDITY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB	Aneurin Bevan LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf LHB	Hywel Dda LHB	Powys LHB	Velindre NHS Trust
OPR submission received by the 14th	-	-	✓	✓	✓	✓	✓	✓	✓	✓
Number of Records Loaded	-	1103985	175152	200687	216258	176054	159136	153305	18428	4965
Administrative Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Birth	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Patient Referral	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Practice Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Local Health Board of Residence	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Main Specialty (consultant)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	94.3	✓	✓	✓	73.3	✓	✓	✓	✓
Postcode of Usual Address[†]	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrer Code	98%	93.0	91.6	91.5	93.5	91.0	94.1	96.3	97.6	✓
Referring Organisation Code	98%	✓	✓	✓	97.2	95.5	✓	✓	97.8	✓
Referrer Priority Type	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Referral: Outpatients	98%	✓	✓	✓	✓	✓	✓	93.3	✓	✓

Referrer code	Linked to above issues – See Section 1.2 of report and Appendix 3.

ALL-WALES EDDS (MAJOR A&E UNITS) DATA VALIDITY PERFORMANCE MONITORING REPORT 2013-14

LHB Site	DATA VALIDITY STANDARD	All Welsh Providers	Abertawe Bro Morgannwg University LHB		Aneurin Bevan LHB		Betsi Cadwaladr University LHB			Cardiff & Vale University LHB	Cwm Taf LHB		Hywel Dda LHB		
			Morriston Hospital	Princess of Wales Hospital	Nevill Hall Hospital	Royal Gwent Hospital	Wrexham Maelor Hospital	Ysbyty Glan Clwyd	Ysbyty Gwynedd (non Psychiatric)	University Hospital Wales	Prince Charles Hospital	The Royal Glamorgan Hospital	Bronglais General Hospital	West Wales General Hospital	Withybush General Hospital
EDDS submission received by the 10th	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Number of Records Loaded	-	799198	85059	56543	45687	85707	68938	57176	49212	130958	57493	60020	25116	39490	37799
Activity at Time of Injury	98%	92.8	✓	✓	✓	✓	✓	✓	0.0	93.4	✓	✓	✓	✓	✓
Alcohol Indicator	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriateness of Attendance	98%	75.3	✓	✓	✓	✓	1.9	✓	✓	1.0	✓	✓	✓	✓	✓
Arrival Mode	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethnic Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Practice Code	98%	✓	✓	✓	✓	✓	92.4	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date	98%	78.0	✓	✓	✓	96.4	0.0	72.3	0.0	72.1	✓	✓	✓	✓	96.4
Health Event Time	98%	73.0	✓	✓	✓	96.4	0.0	1.5	0.0	72.2	✓	✓	✓	✓	97.0
Injury Location Type	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mechanism of Injury	98%	93.8	✓	✓	✓	✓	✓	✓	0.0	✓	✓	✓	✓	✓	✓
NHS Number	95%	✓	✓	✓	✓	✓	✓	94.2	✓	90.9	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	91.4	✓	✓	94.4	✓	✓	91.1	92.8	63.7	✓	✓	✓	✓	✓
Organisation Code (Local Health Board of Residence)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	96.6	97.8	✓
Outcome of Attendance	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode of Usual Address†	98%	✓	✓	✓	✓	✓	✓	✓	97.7	✓	✓	✓	✓	✓	✓
Referrer Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	88.0	94.3	93.9
Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Road User	98%	93.8	✓	✓	✓	✓	✓	✓	0.0	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Service Request	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sport Activity	98%	93.8	✓	✓	✓	✓	✓	✓	0.0	✓	✓	✓	✓	✓	✓
Treatment End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Triage Category	98%	✓	✓	✓	✓	✓	97.0	96.2	✓	✓	✓	✓	✓	✓	✓

ALL-WALES EDDS (MAJOR A&E UNITS) DATA CONSISTENCY PERFORMANCE MONITORING REPORT 2013-14

LHB / Site	DATA CONSISTENCY STANDARD	All Welsh Providers	ABMU LHB		Aneurin Bevan LHB		Betsi Cadwaladr LHB			Cardiff & Vale LHB	Cwm Taf LHB		Hywel Dda LHB		
			Morriston Hospital	Princess of Wales Hospital	Nevill Hall Hospital	Royal Gwent Hospital	Wrexham Maelor Hospital	Ysbyty Glan Clwyd	Ysbyty Gwynedd (non Psychiatric)	University Hospital Wales	Prince Charles Hospital	The Royal Glamorgan Hospital	Bronglais General Hospital	West Wales General Hospital	Withybush General Hospital
Number of Records Loaded	-	799198	85059	56543	45687	85707	68938	57176	49212	130958	57493	60020	25116	39490	37799
Treatment End Date vs. Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Treatment End Date/Time	98%	✓	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Outcome of Attendance	98%	61.5	✓	✓	88.9	88.9	33.3	0.0	n/a	✓	50.0	✓	n/a	0.0	n/a
Birth Date vs. Admin Arrival Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Admin End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Health Event Date	98%	✓	✓	✓	✓	✓	n/a	✓	n/a	✓	✓	✓	✓	✓	✓
Birth Date vs. Treatment End Date	98%	✓	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative Arrival Date/Time	98%	✓	✓	✓	✓	✓	n/a	✓	n/a	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	n/a	✓	n/a	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Treatment End Date/Time	98%	✓	✓	✓	✓	✓	n/a	✓	n/a	✓	✓	✓	✓	✓	✓
Activity at Time of Injury vs. Road User	98%	✓	✓	✓	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓
Activity at Time of Injury vs. Sports Activity	98%	✓	✓	✓	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓
Attendance Group vs. Activity at Time of Injury	98%				☐	☐	☐	☐					☐			
Attendance Group vs. Injury Location Type	98%				☐	☐	☐		☐			☐	☐			
Attendance Group vs. Mechanism of Injury	98%			☐	☐	☐						☐	☐			
Attendance Group vs. Road User	98%	☐	☐	☐	☐	☐	☐	☐				☐	☐	☐	☐	☐
Attendance Group vs. Sport Activity	98%	☐		☐	☐	☐	☐	☐				☐	☐	☐	☐	☐
Arrival Mode vs. Ambulance Incident Number	98%	88.1	67.4	✓	✓	✓	92.9	✓	✓	97.3	73.7	73.8	79.1	76.0	71.3
Attendance Category vs. Alcohol Indicator	98%	✓	✓	✓	✓	✓	✓	✓	97.3	✓	✓	✓	✓	✓	✓
Attendance Category vs. Appropriateness of Attendance	98%	✓	95.2	✓	✓	✓	✓	✓	97.3	✓	✓	✓	94.6	✓	96.0
Attendance Category vs. Arrival Mode	98%	✓	95.2	✓	✓	✓	✓	✓	97.3	✓	✓	✓	94.6	✓	96.2
Attendance Category vs. Triage Category	98%	93.2	✓	✓	✓	✓	✓	n/a	0.1	✓	✓	93.3	94.2	66.8	✓
Postcode vs. Organisation Code (LHB of Residence)*	98%	✓	✓	✓	96.6	✓	✓	✓	✓	97.4	✓	✓	97.2	✓	✓
Referrer Code vs. Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Arrival Mode vs. Ambulance Incident Number	Ambulance Incident Number is not recorded on Myrddin – caveat on NWIS performance report.	Refer to section 1.4.1. of report for more details.
Attendance Category data items	Data mapping issues now been resolved	

ALL-WALES EDDS (MIU'S & MINOR A&E UNITS) DATA VALIDITY PERFORMANCE MONITORING REPORT 2013-14

LHB / Site	DATA VALIDITY STANDARD	All Welsh Providers	ABMU LHB – Neath Port Talbot Hospital	ABMU LHB – Singleton Hospital	Aneurin Bevan LHB – Ysbyty Aneurin Bevan	Aneurin Bevan LHB – Ysbyty Ystrad Fawr	Betsi Cadwaladr – Bryn Beryl Hospital	Betsi Cadwaladr – Dolgellau and Barmouth District Hospital	Betsi Cadwaladr – Llandudno General Hospital	Betsi Cadwaladr – Tywyn & District War Memorial Hospital	Betsi Cadwaladr – Ysbyty Alltwen	Betsi Cadwaladr – Ysbyty Penrhos Stanley	Cardiff & Vale LHB – The Barry Hospital	Cwm Taf – Ysbyty Cwm Cynon	Cwm Taf – Ysbyty Cwm Rhondda	Hywel Dda – Llandovery Hospital	Hywel Dda – New Tenby Cottage Hospital Outpatients	Hywel Dda – Prince Philip Hospital	Hywel Dda – S. Pembs Hosp. Health & Social Care Res Centre	Powys – Breconshire War Memorial Hospital	Powys – Llandrindod Wells Hospital
EDDS submission received by the 10th	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Number of Records Loaded	-	200461	38087	9177	7807	29420	1692	2526	19067	1901	3329	4046	8271	8642	7157	205	2848	34351	1965	7281	7002
Activity at Time of Injury	98%	83.7	✓	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	97.6	✓	✓	✓	✓	✓	✓	✓	✓
Alcohol Indicator	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriateness of Attendance	98%	85.9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	0.0	✓	✓	✓	✓	✓	✓	0.0	0.0
Arrival Mode	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethnic Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Practice Code	98%	✓	✓	88.8	✓	✓	✓	✓	✓	97.5	✓	✓	✓	✓	✓	✓	97.9	✓	✓	✓	✓
Health Event Date	98%	77.7	✓	0.0	94.2	95.6	0.0	0.0	0.0	0.0	0.0	0.0	89.7	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Time (*not recorded on Adastra system)	98%	77.8	✓	*0.0	94.2	95.6	0.0	0.0	0.0	0.0	0.0	0.0	89.8	✓	✓	✓	✓	✓	✓	✓	✓
Injury Location Type	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mechanism of Injury	98%	83.8	✓	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number	95%	✓	✓	✓	✓	✓	87.9	87.5	94.6	91.8	89.1	94.1	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	94.8	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	94.9	✓	✓	90.3	91.3	86.9	86.2	93.2	91.6	87.6	92.3	75.2	✓	✓	✓	✓	✓	✓	✓	✓
Organisation Code (Local Health Board of Residence)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	96.1	91.0	✓	97.8	92.3	96.1
Outcome of Attendance	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode of Usual Address†	98%	✓	✓	✓	✓	✓	93.3	94.7	✓	94.8	94.8	97.3	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrer Code	98%	97.1	✓	✓	✓	✓	✓	✓	✓	✓	97.1	✓	✓	✓	✓	94.6	89.9	90.8	87.2	91.8	88.5
Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Road User	98%	83.8	✓	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Service Request	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sport Activity	98%	83.8	✓	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Triage Category	98%	90.0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	0.0	0.0

LHB / Site	DATA VALIDITY STANDARD	All Welsh Providers	ABMU LHB		Aneurin Bevan LHB		Betsi Cadwaladr University LHB						Cardiff & Vale LHB	Cwm Taf University LHB		Hywel Dda University LHB				Powys Teaching LHB			
			Neath Port Talbot Hospital	Singleton Hospital	Ysbyty Aneurin Bevan	Ysbyty Ystrad Fawr	Bryn Beryl Hospital	Dolgellau and Barmouth District Hospital	Llandudno General Hospital	Tywyn & District War Memorial Hospital	Ysbyty Alltwen	Ysbyty Penrhos Stanley	The Barry Hospital	Ysbyty Cwm Cynon	Ysbyty Cwm Rhondda	Llandovery Hospital	New Tenby Cottage Hospital Outpatients	Prince Philip Hospital	S. Pembs Hosp. Health & Social Care Res Centre	Breconshire War Memorial Hospital	Llandrindod Wells Hospital	Victoria Memorial Hospital	Ystradgynlais Community Hospital
Number of Records Loaded	-	200461	38087	9177	7807	29420	1692	2526	19067	1901	3329	4046	8271	8642	7157	205	2848	34351	1965	7281	7002	4899	788
Treatment End Date vs. Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Treatment End Date/Time	98%	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓
Attendance Group vs. Outcome of Attendance	98%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Birth Date vs. Admin Arrival Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Admin End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Health Event Date	98%	✓	✓	n/a	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Treatment End Date	98%	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	n/a	n/a	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative Arrival Date/Time	98%	✓	✓	n/a	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative End Date/Time	98%	✓	✓	n/a	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Treatment End Date/Time	98%	✓	✓	n/a	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓
Activity at Time of Injury vs. Road User	98%	87.8	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	✓	97.6	✓	✓	✓	✓	✓	0.0	0.0	0.0	0.0
Activity at Time of Injury vs. Sports Activity	98%	87.6	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	95.7	✓	✓	✓	✓	✓	✓	0.0	0.0	0.0	0.0
Arrival Mode vs. Ambulance Incident Number	98%	97.5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	87.5	✓	97.9	97.9	✓	✓
Attendance Category vs. Alcohol Indicator	98%	97.9	✓	✓	✓	✓	92.0	96.6	86.8	96.1	91.8	✓	✓	✓	✓	✓	97.8	✓	✓	✓	97.6	✓	✓
Attendance Category vs. Appropriateness of Attendance	98%	97.2	✓	✓	✓	✓	92.0	96.6	86.8	96.1	91.8	✓	n/a	✓	✓	✓	97.8	95.9	✓	n/a	n/a	n/a	n/a
Attendance Category vs. Arrival Mode	98%	96.0	✓	✓	✓	✓	92.0	96.6	86.8	96.1	91.8	✓	✓	✓	✓	✓	97.8	96.0	✓	83.9	79.9	85.4	90.0
Attendance Category vs. Triage Category	98%	77.0	✓	n/a	✓	✓	0.0	3.5	0.0	0.0	20.5	0.0	✓	✓	✓	n/a	✓	✓	✓	n/a	n/a	n/a	n/a
Postcode vs. Organisation Code (LHB of Residence)*	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	96.9	94.8	✓	✓	✓	✓	✓	✓
Referrer Code vs. Referring Organisation Code	98%	97.9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	24.3	✓	✓	✓	✓	✓	✓	✓	✓

Swansea Heart Failure Service

Hospital In-Patient Episode Final Primary Diagnosis
(to assist coding for the National Heart Failure Audit)

Patient ID Sticker:	Consultant	Date of Admission:
	Ward:	Date of Expected Discharge:

National Heart Failure Audit (NICOR)

UCL

This mandatory audit collects data on all patients discharged from hospital with a diagnosis of heart failure in the primary position (the main condition treated or investigated during the episode of care) for the following ICD-10 codes:

Medical Team please tick appropriate box PRE-DISCHARGE if the following applies:

HEART FAILURE DIAGNOSIS	IC10 code	Please Tick
Congestive Heart Failure	I50.0	
Left Ventricular Failure	I50.1	
Heart Failure, unspecified	I50.9	
Hypertensive Disease with Congestive Cardiac Failure	I11.0	
Dilated Cardiomyopathy	I42.0	
Ischaemic Cardiomyopathy	I25.5	
Cardiomyopathy, unspecified	I42.9	
Has an echocardiogram or other imaging confirmed the above?	YES/ NO If 'No' is an Echo planned? YES/NO	
NB: If Heart Failure was suspected on admission but other definitive diagnosis confirmed prior to discharge PLEASE DOCUMENT >>>		

DESIGNATION	PRINT NAME	SIGNATURE	DATE

Audit Team: Consultant Cardiologists: Dr G Jenkins (Lead) / Dr R Purnell; HF Specialist Nurses: KB Roberts/BL Mayer; Audit Assistant: M Thornton

EXTERNAL CLINICAL CODING REVIEW (ACCURACY OF CODING) – Conducted by NHS Wales Informatics Service (National Auditor)

PRINCESS OF WALES	%	NEATH PORT TALBOT	%	MORRISTON	%	SINGLETON	%
OVERALL FINDINGS		OVERALL FINDINGS		OVERALL FINDINGS		OVERALL FINDINGS	
Primary Diagnosis	88.89%	Primary Diagnosis	91.21%	Primary Diagnosis	91.21%	Primary Diagnosis	86.96%
Secondary Diagnosis	85.84%	Secondary Diagnosis	81.56%	Secondary Diagnosis	91.57%	Secondary Diagnosis	85.92%
Primary Procedure	92.98%	Primary Procedure	96.30%	Primary Procedure	80.49%	Primary Procedure	89.55%
Secondary Procedure	95.16%	Secondary Procedure	95.15%	Secondary Procedure	90.27%	Secondary Procedure	84.44%
General Surgery		OVERALL FINDINGS		OVERALL FINDINGS		OVERALL FINDINGS	
Primary Diagnosis	90.00%	Primary Diagnosis	100%	Primary Diagnosis	93.33%	Primary Diagnosis	86.67%
Secondary Diagnosis	80.00%	Secondary Diagnosis	86.36%	Secondary Diagnosis	92.86%	Secondary Diagnosis	88.24%
Primary Procedure	95.83%	Primary Procedure	96.43%	Primary Procedure	83.33%	Primary Procedure	96.67%
Secondary Procedure	98.21%	Secondary Procedure	96.83%	Secondary Procedure	80.00%	Secondary Procedure	85.07%
General Medicine		OVERALL FINDINGS		OVERALL FINDINGS		OVERALL FINDINGS	
Primary Diagnosis	93.33%	Primary Diagnosis	83.33%	Primary Diagnosis	96.67%	Primary Diagnosis	90%
Secondary Diagnosis	91.96%	Secondary Diagnosis	81.15%	Secondary Diagnosis	91.14%	Secondary Diagnosis	84.48%
Primary Procedure	92.31%	Primary Procedure	100%	Primary Procedure	100%	Primary Procedure	88.89%
Secondary Procedure	100%	Secondary Procedure	100%	Secondary Procedure	91.67%	Secondary Procedure	71.43%
Trauma & Orthopaedics		OVERALL FINDINGS		OVERALL FINDINGS		OVERALL FINDINGS	
Primary Diagnosis	83.33%	Primary Diagnosis	90.63%	Primary Diagnosis	83.87%	Primary Diagnosis	83.33%
Secondary Diagnosis	79.03%	Secondary Diagnosis	76.79%	Secondary Diagnosis	90.79%	Secondary Diagnosis	86.21%
Primary Procedure	90.00%	Primary Procedure	93.10%	Primary Procedure	73.91%	Primary Procedure	82.14%
Secondary Procedure	91.38%	Secondary Procedure	93.55%	Secondary Procedure	94.37%	Secondary Procedure	86.96%

CLINICAL CODING IMPROVEMENT ACTION PLAN   - April 2014 / March 2015
LEAD – CHRISTINE THOMAS, CODING MANAGER   AREA – CODING DATA QUALITY

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
Improve the Timeliness of Clinical Coding Completeness	Efficient Coding Support arrangements in place across the 4 Coding Departments	Ensure support staff are efficiently dealing with the daily throughput of activity to support case note flows by:- • Validating/tracking and filing all notes entering the department in strict month order. • Ensure all 'Daily's or Urgent fast –track case notes are addressed in accordance with departmental priorities and timescales. • Extract outstanding lists from the Information Portal • Visit all filing areas to retrieve/locate outstanding case notes for coding purposes • Retrieve all backlog episodes for all 4 sites from the individual libraries. • Visit wards, secretaries offices and departmental areas for location of outstanding case notes. • In conjunction with Coding Supervisor proactively liaise with ward and departmental staff to establish the location of outstanding discharges for coding purposes and agree processes going forward. • If problems exist at ward level i.e. temporary folders/case note flows/data quality issues, report to Coding Supervisor for escalation with the appropriate ward manager/receptionist/ Health records teams. • Liaise with coding counterparts, and transfer case notes across hospital sites to assist/address departmental backlog issues. • Coding supervisors to provide daily/weekly guidance on the main areas for targeting/ prioritising in line with completeness figures/targets and process changes. •	Coding completeness (monitored at 6/8 and 12 weeks intervals for Health Board/ WAG All Wales targets/submissions New targets implemented April 2013 (see below) Regular update meetings with Coding Support Staff.	Ongoing process

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS

	Tier 1 WAG Coding Targets implemented April 2013	The Information Portal has been enhanced to provide additional functionality in support of the Tier 1 Coding Targets:-
		
		• Coding views were enhanced to display the targets in the same format as the WAG Tier 1 targets to highlight:-
		   • The exact number of outstanding episodes required per month/per site/per speciality to meet the 95% & 98% completeness targets.
		   • The coding completeness traffic light percentage cubes have also been amended to reflect the overall percentages required across all specialties & patient class.
		
		The Coding Teams have been instructed to access the new coding views to inform the daily priorities.
		
		The Coding Teams are committed to addressing/improving the Coding Completeness levels across ABMU.
			Tier 1 Targets
			
			• 95% completeness adhered to on an ongoing monthly basis
			
			• 98% completeness is delivered for any rolling 12 month period within 3 months.
			
			• Ensure both standards are applied across all episodes/specialities
				Ongoing
				
				Ongoing

	Address areas of poor performance	• Review the Information Portal to obtain an up to date snapshot of outstanding activity by ward/speciality/directorate. • Arrange for support staff to visit all wards to collect any temporary folders with outstanding coding. • Establish where outstanding pockets of activity are located, and plan how to target these areas as a team. • Contact ward managers, reception staff to establish outstanding discharges for coding purposes and arrange collection. • Supervisory staff to distribute departmental memo across all ward areas to ensure staff are aware of the importance/function of coding stickers. • E-mail/and meet with Directorate colleagues to report on directorate coding completeness/areas of poor performance and agree actions to rectify issues.(Meet quarterly)	Coding supervisors to provide daily/weekly guidance on the main areas for targeting in line with completeness figures/targets. Directorates updated on Coding Completeness as part of Directorate Review process. Coding Completeness reported at Executive Level, at the Clinical Outcome Steering Group & Information Standards Board Meetings Conduct 6 monthly audit of coding sticker compliance at ward level.	Ongoing

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
	Improvements to Mental Health Coding Completeness	The Coding Management Team continue to support and work closely with Mental Health Directorate Colleagues to further improve MH performance. The following processes have been implemented going forward:- • Monthly completeness reports are e-mailed to Directorate colleagues. • Discharge Summaries are e-mailed to the coding supervisors & available electronically for coding purposes. • An interim discharge summary of the care form is provided to the coding team (This is in cases where patients are <u>transferred</u> across ABMU, but discharged on PAS resulting in an additional episode for coding) which by-passes the coding process. • All MH managers have been provided with access to the Information Portal and list facilities to review performance and make the necessary actions	Quarterly Multi Disciplinary Meetings are held with MH Directorate Managers Mental Health Coding Completeness achieves 95% & 98% target	In Progress (Ongoing) April 2014

Improve the Timeliness of Clinical Coding Completeness	Support new ways of working to improve the timeliness and efficiency of clinical coding across the 4 hospital sites.	• Staff are required to be flexible in their place of work in order to address specific coding backlogs/Year End completeness:-
		  • Team to be adaptable in support of service demand/changes.
		  • Explore opportunities to work in other departmental/ward areas i.e. cardiac, fracture clinic, PAU if backlogs exist.
			Internal processes to be continually monitored and reviewed to further improve performance.	Ongoing

	All Outstanding episodes coded by dept in receipt of the case note(regardless of site of treatment)	• Processes implemented to ensure that case notes held in the coding office that are required for admission or OPD clinic are priority coded before leaving the office. • An e-Mail request system has been implemented in support of the above process.	100% of case notes entering the department, leave the department with no outstanding episodes	Ongoing

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
Improve the Timeliness of Clinical Coding Completeness	Workforce plan/reorganisation of staffing compliment in line with service demand.	• Processes are in place to continually review the WTE staff numbers per department, in line with staff retiring/reducing hours to ensure resources are allocated appropriately across the 4 hospital sites. • All new staff recruited will be required to work across any of the 4 hospital sites as required, in line with service change/demand.	Ratio of coder>episodes per site (daily)	Implemented 2012 Ongoing process
	Utilisation of all available electronic resources for coding staff	• All staff are provided with electronic systems to support timely coding i.e. Review/ Discharge Summaries/ IMPAX, Chemo Care. • Theatre Operational Management System (TOMS) has been rolled across the Health Board. • Arrangements are in place to provide coders with access to CANISC • Arrangements are also in place to provide the coders with access to the Document Management System to review Clinical letters and documentation.	Coders provided with all electronic means to complete their coding duties.	Completed Completed Planned August 2014
	Deceased Coding	• Robust processes are in place across all four coding departments to ensure the timely location and coding of deceased episodes in line with health board targets. • Compliance is monitored on a monthly basis, and any outstanding case notes which cannot be located are escalated to supervisory staff. • (See departmental procedures) • Any deceased records unable to be coded due to missing/or no clinical information contained are to be raised as 'Clinical Incidents'.	Deceased notes to be coded within 1 month. Balanced budget Position Investigations can be undertaken on why clinical information is not contained within the case note folder.	Ongoing Implemented June 2014
	Overtime Working	• Coding Management Team to review the current overtime working across the department in line with financial budget. • Coding supervisors to have robust procedures in place for overtime working, to ensure that authorisation, prioritisation and service demand issues are being accounted for. • All overtime throughput to be monitored to ensure required productivity is being achieved.		

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
Improve the Depth of Coding	Introduction of key awareness documentation for Clinician Staff	• Coding Bookmark developed and displayed on Information Portal. • Coding Bookmarks are provided to clinical teams. • Coding Bookmark are circulated as part of the Junior Doctors Induction Packs • Coding Poster developed for display across key areas of the Health Board • Coding Video needs to be developed for inclusion at Junior Doctors Induction/ within Doctors Mess/ available as link on Intranet	Bookmark available across all ward and departmental areas- 100% audit quarterly. Posters to be displayed across all ABM key areas. Awareness Video available across ABMU	Ongoing Completed 2013 Outstanding for development
	Raise Profile of Clinical Coding Function	• Coding Managers continue to raise the profile of the Coding Service by presenting at Clinical/Management Forums as necessary. • Currently looking at the feasibility of delivering sessions to the Junior Doctors at part of their foundation training. • Currently providing coding presentation on a monthly basis to medical directorate staff at the princess of Wales Hospital • An Informatics Induction Programme is also delivered to all new A&C staff • Delivering additional awareness presentations to Ward managers/receptionists/and as part of management programmes • Plans to attend Multi Disciplinary Directorate Meetings • Coding Supervisory staff are actively engaging with Clinician teams to update on Coding rules	Present as part of Core Medical Training Evidence of delivery of regular monthly development programmes. Attendance on a monthly basis	Outstanding Outstanding Ongoing Ongoing Ongoing Commenced April 2014
Improve the Depth of Coding	Availability of Discharge Summary at the point of Coding	• Coding Supervisory teams have also assisted clinical staff in developing the top 20 (ICD-10) diagnostic codes to support clinicians and coding staff in accurate recording of information. • Coding Supervisors are actively supporting the Discharge Summary leads across ABM Health Board, to inform of areas of good/bad discharge summary compliance. • All coding staff actively utilise electronic discharge summaries to assist with coding duties.	Discharge Summary completion monitored at Executive Level Overall Discharge Summary compliance improves.	Ongoing Ongoing
	Implementation of Co-morbidities	• Keep coding staff fully updated with co-morbidity discussions at All Wales Level	Ensure all coding staff are up to date 100% of coders coding in line with	Ongoing

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
	(Coding Clinic)		latest co-morbidity guidance.	
Improve the Accuracy/ **Consistency of Coding**	Increase the number of ACC Qualified Coders	• Mandatory for all new coding trainees to sit the ACC qualification and gain accreditation. • All Coding staff are encouraged to gain the ACC qualification. • Robust training and mentorship programme implemented to support coding staff with attaining the ACC qualification • (46% of staff are currently ACC qualified)	100% ACC (Trainee staff) 70% of coders to attain the qualification by 2016	Ongoing
	All coders to attend the relevant training courses to update knowledge and skills base	• All coding staff to attend the relevant coding workshops annually to update their skills and knowledge.	100% of trainee coders to receive their basis training within 12m of appointment 100% of coders to attend speciality workshops in line with guidance	Completed & Ongoing
	All staff to have an annual Personal Development Review (PDR)	• Supervisor's conduct PDR with their coding teams, in line with departmental objectives and supported by individual audits. • Staff responsible for keeping their PDP's updated	100% of coders receive an annual PDR. 95%+ Coding Accuracy (monitored by individual audit)	Ongoing
	Implement Coding Clinics in a timely manner, in line with All Wales publication.	• Ensure adequate provision is provided to all coding staff to read through latest coding clinics and annotate their coding books/ manuals accordingly. • Coding supervisors to discuss updates with Coding Team	Snapshot audit of coders coding in line with latest coding guidance. Review Coders OPCS/ICD-10 manuals.	Ongoing
Improve the Accuracy/	ABM Audit Programme	• Regular audits to be conducted on a rolling programme. • Coding Teams to assist with Mortality Reviews when required.	New Audit Lead to develop robust ABMU Audit Programme.	Ongoing

CLINICAL CODING DRIVERS	INTERVENTIONS	ASSOCIATED ACTIONS	MEASURES	STATUS
Consistency of Coding	Electronic Audit Tool to support Audit Programme	An electronic audit tool has been developed in conjunction with the coding supervisory team and Information Development team which provides the following functionality:- • The auditor is able to randomly select a pick list of records for specified known records for audit purposes • The auditor is able to review the actual coding contained for each patient record and verify each episode. • The auditor is able to validate and amend the coding contained if errors are identified • The auditor is therefore able to review, amend, generate reports on audit findings, which provides an overview of the % accuracy for both diagnosis & procedure coding. This information is graphed and the auditor can document all the recommendations and conclusions from the audit. • This is used as part of the PDR process and produces a report for the individual coder plotting performance against peer performance for a variety of measures for the coding of Diagnoses, Procedures and Morphology.	Conduct Internal/Individual audits in support of ABMU Audit Programme	Ongoing
	Clinical Engagement	• Coding staff will be encouraged to meet with clinical staff to discuss coding related queries • The Coding Supervisory Team have been involved in developing the Top 20 most common diagnosis codes for Electronic Discharge Summaries. • Coding Supervisors are regularly meeting with clinical teams to raise awareness of coding rules and national standards. • Clinical Coding Champions are to be sought, to improve coding process.	Overall Improvements to Clinical content within the casenote folder.	
	Data Quality Indicators	• Working closely with the Data Quality Teams to address administrative errors and make improvements to data capture. • Ensure that consistent errors presented from an individual area/ward are addressed/ reported via the appropriate channels. • Ensure data capture/quality issues are discussed with Data Quality co-ordinator.	Monitor via Information Data Quality Portal.	Ongoing