CHKS
Insight for better healthcare

# The Royal Wolverhampton NHS Trust

## Arrangements review for clinical coding

June 2015

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# About CHKS

CHKS is a leading provider of healthcare intelligence and quality improvement services. Since 1989 we have been developing hospital benchmarking and performance management solutions for healthcare organisations in over 20 countries and have worked with over 400 clients throughout the world.

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# SUMMARY

1. This draft report contains the findings from the review undertaken by CHKS on behalf of The Royal Wolverhampton NHS Trust of the Trust's Clinical Coding Department.

2. We examined the Clinical Coding Department plans and processes to:

    - understand what improvements have been put in place during a period of three financial years from 2012/13 to 2014/15; review audit reports undertaken over the three year period and their recommendations; and
    - assess the action plans following the audit recommendations and their progress.

3. The trust has made improvements in all areas over the last three years, based on the documentary evidence supplied and interviews with Trust staff. Positive improvements included:

    - an increase in the size of the team from 17 to 26 coders to manage increasing annual FCE volumes;
    - an internal coaching programme;
    - introducing a formal audit programme with regular external audits supplemented by internal coder level reviews by experienced coders;
    - moving from ward based to office based coding; and
    - increasing qualified clinical coders from 2 to 11 through the Trust's training plan.

4. Improvements could be made in some areas:

    - some presentational issues were found in documentation and regular checks of IG-toolkit requirements;
    - detailed documentary evidence of system mapping, data quality checks, interaction with the coding team and actions from governance meetings requires some improvement;
    - although regular clinical engagement for mortality checks and coder queries was good, a more formal plan for clinical engagement needs to be embedded across all specialties; and,
    - some action plan versions would benefit from full details of start date, completion date for individual actions to improve records.

## Recommendations

5. Based on the review completed we have made seven recommendations, which have been included in an action plan (Appendix 1) to be completed by the Trust.

# BACKGROUND AND APPROACH

## Introduction

6. The Royal Wolverhampton NHS Trust on behalf of the Mortality Review Assurance Group (MoRAG) asked CHKS to provide an independent view on the progress and achievements made against a planned programme of change instigated within the Trust's clinical coding team in 2011/12. Findings from this review will be supported by an action plan to focus on improving the effectiveness of the coding department and plans to support delivery of the plan.

## Approach

7. The review examined the improvement processes for the Clinical Coding Department initiated by the Trust three years ago on appointing an Acting Head of Clinical Coding and Data Quality (Acting Head).

8. We examined the Clinical Coding Department to:

    - understand what improvement processes have been put in place during the three financial years from 2012/13 to 2014/15;
    - review of audit reports undertaken over a three year period and their recommendations; and
    - assess the action plans following the audit recommendations and their progress.

9. To do this we met with service managers, clinicians and information leads to review the governance arrangements for the accurate collection and recording of data (as identified in paragraph 14).

10. A selection of individual patient case notes were reviewed in conjunction with the clinician involved in care delivery to determine if they are an accurate reflection of the patient pathway and classified in line with national guidance or local commissioning intentions.

11. All findings have been agreed with the Trust.

## CHKS

12. CHKS has been providing independent, external data assurance audits for the Audit Commission as part of the Payment and Tariff Assurance Framework (previously the PbR data assurance framework) for the last eight years. In 2014/15, we are overseeing the management and delivery of the entire framework on behalf of the Monitor. The staff responsible for developing the methodologies used by the assurance framework led the work at The Royal Wolverhampton NHS Trust.

# CLINICAL CODING IMPROVEMENT PROCESSES

## Scope

13. An onsite review of the clinical coding team's current processes took place over two days at the Trust. This was supplemented through offsite review of additional documents and audit reports from the last three years for a comparison review.

14. Interviews took place with the following Trust staff:

    - Acting Head of Clinical Coding and Data Quality;
    - Experienced Coder;
    - Service Manager for Cancer Services;
    - Data Quality Co-ordinator;
    - Head of Information;
    - Patient Access Manager/ Health Records Manager; and
    - Care of the Elderly Consultant.

15. This review identified whether the appropriate processes are in place to support high quality coded data by following a proven methodology. It looked at a number of key areas and assessed them against a number of criteria including:

    - clinical coding team – an assessment of sufficient staffing levels, qualified clinical coders and support arrangements for high performance;
    - clinical coding outputs – the accuracy of coding carried out by the coders over the past three years;
    - documentation review – what information is recorded, how it is recorded and the process for presenting information to the clinical coding team;
    - data quality – how the Trust ensures high levels of data quality and identifies errors in its coded data and a review of IG audit reports over the last three years;
    - clinician engagement - through individual interviews, a look at the relationship and participation of clinicians and service managers within the coding process, to collaboratively improve coding outputs; and
    - reporting – the feedback processes to clinicians and management about coded data and how the feedback is used.

16. Appendix 2 sets out the scope of the audits over the last three years, the specialties audited and results.

## Clinical coding team

17. The Trust acquired responsibility for Cannock Chase Hospital last November 2014. The coding team also codes at West Park Hospital rehabilitation centre now three coders for two days each week on a rotational basis. Out-patient coding is carried out by a data input clerk based in the coding team via coding pro formas developed by the Coding Team and implemented within services.

18. The Trust's clinical coding team has increased from 17 coders (14.37 WTE) in January 2013 to 22 coders (18.24 WTE) in February 2015, an increase in WTE of 27% as shown in Table 1 below. A further increase in June 2015 to 26 coders (25.03 WTE) reflects a 75% WTE increase from January 2013. Qualified coders have also increased in June 2015 from 8 to 11 as a direct result of the Trust's internal training programme.

*Table 1: Clinical coding team staffing from 2013 to 2015*

| | 2011 | 2012 | Mar 2013 | Jul 2013 | Apr 2014 | Dec 2014 | Feb 2015 | Jun 2015 |
|---|---|---|---|---|---|---|---|---|
| Head of Clinical Coding & Data Quality[1] | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Team manager [2] | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |
| Coders | 17 | 17 | 17 | 16 | 15 | 19 | 22 | 26 |
| WTE | 14.0 | 13.66 | 13.39 | 13.84 | 12.37 | 15.63 | 18.24 | 25.03 |
| ACC qualified | 2 | 3 | 4 | 4 | 4 | 8 | 8 | 11 |
| Assistants WTE | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Data input clerk WTE | 0.77 | 0.77 | 0.77 | 0.77 | 0.93 | 0.93 | 0.93 | 0.93 |
| Trainees WTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2.61 | 2.61 | 2.61 |
| Vacancies WTE | 0.0 | 0.0 | 1.75 | 2.28 | 4.57 | 0.0 | 0.0 | 1.0[3] |

[1] Manager spends 5% of available time coding

[2] Team managers spend 65% of available time coding

[3] Auditor position

19. The coding team staffing levels and bandings are set out in table 1. Two divisional managers directly reporting to the Acting Head of Clinical Coding and Data Quality. These figures do not take into account the Acting Head's responsibilities for direct reports in the Data Quality team.

20. A new structure has been implemented to include a new management structure with new reporting lines, which aids business continuity and staff progression.

21. Current band levels for the Trust's coding team are listed in table 2 below, alongside working time equivalent (WTE) details, qualified coders and related vacancies.

*Table 2: Clinical coding team band details*

| Band | Number of staff | WTE | ACC qualified | Vacancies |
|---|---|---|---|---|
| Band 6 | 2 | 2.76 | 2 | 1[4] |
| Band 5 | 5 | 3.70 | 5 | 1 |
| Band 4 | 16 | 14.03 | 4 | 0 |
| Band 3 | 2 | 1.60 | 0 | 1 |
| Band 2 | 1 | 0.93 | N/A | 0 |
| Band 1 | 3 | 2.01 | N/A | 0 |
| **TOTAL** | **29** | **25.03** | **11** | **3** |

22. Although staffing has increased, the volume of FCEs that require coding has increased from 155,546 in 2012/2013 to 174,225 in 2014/2015, a 12% increase overall.

23. The Trust applies a target of 8,000 FCEs coded per coder each year. FCE volumes exceeded this target by 1,570 per year per WTE in 2013/14. April 2014's coding audit report noted that each coder needed to code 11,500 a year. This led to the implementation of the coding department restructure and the Trust has plans to recruit a further two trainees and one Band 5 coder / qualified auditor in 2015/16. (FCE volumes and staffing are set out in Appendix 3.)

24. The IG audit report of February 2015 noted that staff need to code 10% more than the Trust's target of 8,000 episodes per WTE each year. There are three coding team vacancies currently, including an auditor position. Staffing levels are adequate to meet the deadline tests and annual volumes of FCEs if these vacancies are filled.

25. Monthly deadlines mean 90%-95% of coding must be completed by the flex target date - that is before the fifth working day of the following month. All coding must be 100% completed by the freeze date within 14 days from the start of the next month. These targets are similar to other Trusts.

[4] Auditor position

26. A robust sickness policy has been applied by the Acting Head of Clinical Coding and Data Quality on appointment three years ago. This has reduced levels of sick leave from a reported high level in 2012/13 to acceptable levels in June 2015, with no long-term sick leave currently. Consequently the coding team has more availability to tackle increased FCE volumes and improve the general smooth running of the department.

27. ACC qualified clinical coders increased from three to eight from March 2013 to February 2015. Recently 3 coders successfully passed ACC qualification, making a total of 11 qualified coders in the team, which is a good ratio of qualified / non-qualified coders. Although two Cannock Chase coders were already qualified on transfer to the Trust, this rise still represents a significant increase in qualified coders from 4 out of 17 staff in 2013 (23.5%); 8 from 22 staff (36.4%) in early 2015, rising to 11 out of 29 staff (37.9%) recently due to the Trust's internal training programme.

28. The Trust had planned to recruit a clinical coding auditor externally but now intends to encourage its own qualified coders to become auditors, as qualified clinical coding auditors are a scarce resource.

29. The Acting Head should continue to encourage coders to train for the ACC qualification and to progress on to auditor or trainer qualification, as this improves general coding knowledge and offers opportunities for more detailed and regular auditing to increase coding quality.

30. Experienced coders carry out checks regularly on a small number of FCEs at coder level. Qualified auditors would enhance this review through detailed coder level audits conducted as part of a formal annual audit programme that includes all specialties.

## Trust documentation

31. The Trust uses case notes as the coding source, supplemented by discharge summaries, pro formas, the Patient Administration System (PAS) portal and additional electronic systems for pathology, radiology and renal. The case notes were of good quality and issues noted in past audit reports have been resolved, such as access to histology results access and poor operation notes.

32. The Trust is gradually moving to scanned patient records as a coding source. Coders sometimes found it difficult to read scanned records but used other sources when there were issues. The Trust should monitor legibility issues to ensure that this does not impact coding quality or coders' ability to maintain their agreed coding volumes.

33. The current policy and procedure document was reviewed on site and was a well laid out and detailed document. The document was due to be reviewed in March 2015 but was delayed to wait for an HSCIC coding update. Consequently the document was out of date in June 2015, although it has been reviewed subsequently and is awaiting approval at the policy committee.

34. Steps must be taken to review the policy and procedure document on the due date or revise the annual review date following line with expected HSCIC updates. The Acting Head should consider allocating this annual review to one of the new team leaders as part of their new job role.

## Arrangements

35. Good arrangements have been noted in audit reports since 2013. These have continued but additional factors have impacted the coding team over the last three years, such as the change ward based coding to an office and coders learning to code different specialties on rotation.

36. Ward coding proved to be a poor environment for accurate coding with no dedicated space for coders to access reference books used during coding. Coders also had little support from colleagues for decision making. Following an audit recommendation in 2011/12, coding began to move from ward to office based coding. This process started in November 2012 and is nearly complete with coding on one ward remaining. Casenotes are collected from wards by clinical coding assistants daily. This initiative enables coders to concentrate fully on coding.

37. Until recently, each coder coded a limited number of all the Trust's specialties. This had the advantage of increasing detailed knowledge of those specialties for one coder but reduced the flexibility within the team to manage all specialties, cope with unexpected sickness, staff turnover or high volumes.

38. Coders have begun to code other specialties, with the aim becoming proficient in all specialties gradually, while retaining support from more expert coders. The Trust should create a plan to ensure all coders gain expertise in every specialty over time but while ensuring good coding quality continues overall.

## Training

39. In 2013, the coding team had mandatory required training including coder refresher courses and foundation courses for new coders. Coder training continues but is now undertaken by the West Midlands Clinical Coding Academy and has extended to include specialty training.

40. The Trust supplements formal training with coaching undertaken by coders experienced in key specialties, such as cardiovascular, ENT and orthopaedics. Lead coders have created training presentations for staff new to certain specialties, following plans to rotate the coding of different specialties.

41. Findings from the IG audit report of March 2013 noted that many of the errors found in that audit appear to be due to a lack of study for the NCCQ (UK) Examination in the department and inadequate understanding of coding theory, rules, regulations and code assignment. All coders had been incorrectly advised about primary diagnostic coding through internal coaching. These issues have been resolved.

42. Training courses are now validated by band 5 or band 6 Team Managers to ensure that the advice is correct and this needs to continue.

## Data quality

43. Data quality standards are maintained at the Trust via PAS and other routine system checks. The Data Quality Team and Head of Information explained measures to resolve anomalies and issues through reports, investigation and corrective actions, such as patient demographic records.

44. The data quality team was proactive in visiting departments to correct data errors or issues found. There was some cross-over of responsibilities for resolving data quality issues between the Data Quality and Information teams. Regular meetings to discuss joint issues and maintain issues log with target dates for completion are helpful in resolving data issues promptly where there is joint responsibility.

45. The Information Team clarified processes and reviews already in place to ensure high quality data. However, some processes or meetings were not formally documented due to time pressures and data deadlines. Internal audits do not take place regularly on processes and resolution of issues. External auditors would require full documentation of systems, system checks and governance meetings to be provided to be assured that all measures were in place to ensure high levels of data quality and information.

## Clinical engagement

46. IG toolkit requirement 12-508 requires Trusts to ensure clinical / care staff from all specialties are involved in validating and using the information derived from the recording of clinical / care activity.

47. Clinical engagement was in place for mortality audits in March 2013. Mortality audits have continued to form the basis of clinical engagement for coding at the Trust, with strong support from rehabilitation and elderly care clinicians undertaking regular checks of deceased patients' records.

48. Progress has been made with regular coding query resolution between clinicians and coders in many specialties, but there is an opportunity for stronger clinical engagement across all specialties and in other services such as pharmacy to review coding of new drugs.

49. To support stronger coding quality, the Trust should consider a more formal clinical engagement programme involving all specialty areas, championed by the Trust's clinical leads to further improve clinical coding standards, data and income and the understanding of coding requirements by clinicians.

50. Presentations from clinicians on physiology, advice on surgical procedures and detailed coding validation would enhance the Trust's internal coder training programme and coding accuracy.

51. The Trust would also benefit from a more targeted comparison of clinicians' treatment records against the clinical coding applied and the HRG outcome. Such a review should include experienced coders to ensure that coding National Standards are always applied and a data quality or IT manager for insight into data recording. The Acting Head of Clinical Coding and Data Quality is ideally placed to lead such a project involving her two areas of responsibility.

## Audits - previous reports, recommendations and action plans

52. The quality of clinical coding for PbR audits for 2014/15 is based on the previous year's national performance (2013/14) for the percentage of spells changing payment:

    - performance that would place the Trust in the best performing 25% of Trusts (lower quartile; 5.2% and below) is judged to be good
    - an error rate that would the Trust in the worst performing 25% of Trusts (upper quartile; 10.5%) is poor
    - otherwise performance is judged to be adequate (last year's average was 7.0%).

53. The 2013/14 national performance for clinical coding has improved from an average error rate of 7.0% to 5.2%. The Trust's performance has exceeded the current average of 5.2% with spell error rates of 4.9% and 3.6% in the last two years respectively as shown in Appendix 2.

54. The IG toolkit requires annual audits of coded clinical data using the Clinical Classifications Service Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications OPCS-4 and ICD-10 and national clinical coding standards. Table 4 includes the IG attainment levels for clinical coding accuracy.

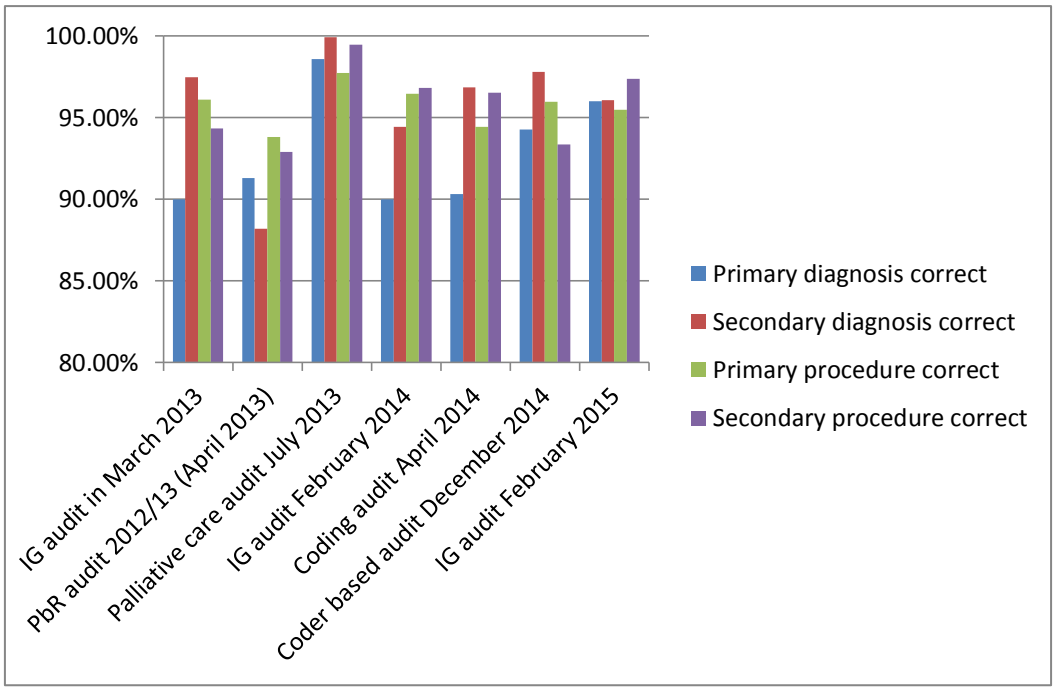
55. The clinical coding audit results for the Trust from the financial year 2012/13 to 2014/15 are set out below in table 4. This highlights the Trust's coding achievements compared with the required IG standards for levels of attainment 2 and 3.

*Table 4: Wolverhampton clinical coding team results 2012-2015*

| | Primary diagnosis correct | Secondary diagnosis correct | Primary procedure correct | Secondary procedure correct |
|---|---|---|---|---|
| **IGT level 3 requirement** | **>=95%** | **>=90%** | **>=95%** | **>=90%** |
| **IGT level 2 requirement** | **>=90%** | **>=80%** | **>=90%** | **>=80%** |
| IG audit in March 2013 | 90.00% | 97.48% | 96.10% | 94.33% |
| PbR audit 2012/13 (April 2013) | 91.30% | 88.20% | 93.80% | 92.90% |
| Palliative care audit July 2013 | 98.58% | 99.92% | 97.74% | 99.46% |
| IG audit February 2014 | 90.00% | 94.42% | 96.45% | 96.82% |
| Coding audit April 2014 | 90.32% | 96.85% | 94.44% | 96.52% |
| Coder based audit December 2014 | 94.26% | 97.80% | 95.95% | 93.36% |
| IG audit February 2015 | 96.00% | 96.08% | 95.48% | 97.36% |

56. Clinical coding audit results can vary according to the speciality and the sample. The results for the Trust have improved since 2012/13 as the Trust has achieved attainment level 3 in all areas in February 2015 (See table 4 above and Chart 1 below.)

*Chart 1: Wolverhampton clinical coding team results 2012-2015*



57. The areas audited since 2012/13 are set out in Appendix 2.

58. The IG audit of March 2013 notes that auditing did not occur previously, apart from formal IG requirements. Since then, the Trust has more than doubled the mandatory audit requirements conducting audits on specific topics, as well as ongoing internal audits by senior coders.

59. External audit topics are chosen according identified local needs and include at least two areas to audit to gain greater value from the external expertise. Audits could be targeted to investigate these hot topics but also to review other areas, such as sub-specialties not audited recently; specialties with high Trust volumes; areas of complex coding or past problem areas that require validation of past training.

60. The Trust's external IG audits also record the number and price impact of HRG changes. Although not a national requirement, this benefits the Trust with insight into the cost of coding errors and highlights concerns for specific areas audited.

61. HRG error rates results varied year on year according to the area audited and were higher for the April 2014 mortality / morbidity comparison as rehabilitation coding issues were identified and coders needed training in the use of signs and symptoms.

62. Depth of coding is reported as a measure of coding quality and the Trust's coding is benchmarked against local averages for comparison. Depth of coding usually describes the number of codes per episode rather than the degree of coding accuracy and does not mean more income is achieved.

63. Depth of coding is a poor indication of coding quality. PbR audit reports record the volume of "not relevant" codes as errors as they may impact on grouping and therefore payment. The Trust should benchmark coding standards using additional clinical coding quality measures, such as the national benchmarker, local Trusts' overall coding data or via specialist data comparison organisations.

64. Audit action plans from 2012/13 to the present time were reviewed (see Appendix 4). Recommendation topics varied from coding errors, staffing needs, departmental arrangements, documentation and system issues and clinical engagement.

65. Most recommendations appear to have been completed in full. Evidence for completed recommendations is not always clear from the action plan version in current daily use. External auditors would seek detailed and specific confirmation that an action had been completed.

66. Coding audits may include incomplete recommendations from previous audits and these should be clearly referenced for clarity. In particular, the date when the initial recommendation was made needs to be recorded. Some recommendations were not specifically included in the relevant action plan, making it unclear what proposed actions were being undertaken.

67. A review of previous action plans should continue in the external audit reports, but a more formal record of the evidence is needed for external auditors. This should demonstrate that all recommendations have been completed in full, and refer to interim actions, specific documents, training courses, meetings and other evidence, including dates.

68. A recommendation for improving clinical engagement was included in the audit of March 2013 and repeated in the last two audit reports. This recommendation to develop clinical engagement across all areas of the Trust has not been completed in full and now requires formal Trust-wide support from clinical leads.

69. Recommendations for staffing improvements took longer than the target dates set out in the plans. Action plans should include realistic milestones to achieve the recommendation and alternative plans if the original recommendation cannot be achieved. For example, the Trust determined that training existing Trust staff to become coders was an alternative to recruiting qualified coders externally. This revised action fulfilled the original recommendation.

## Recommendations

70. Based on the review completed we have made seven recommendations, which have been included in an action plan (appendix 1) to be completed by the Trust.

- Continue to maintain a formal training record for individual coders and an overall training plan for the Clinical Coding Department, including:
    - ongoing rotation of coding staff responsibilities for different specialties: take steps to avoid the loss of coding quality during transition from one specialty to another;
    - continued encouragement for coders to work towards clinical coding qualifications; and,
    - coach experienced coding staff to take over routine management responsibilities.
- Update the policy and procedure document promptly as part of the overall annual departmental plan by the designated due date. (The due date could be changed to a date after the expected HSCIC changes.)
- Consider setting up a project to review of coding standards, data quality and HRGs to develop understanding between coders, information managers and clinicians. (National coding standards must be retained, which requires the input of a qualified or experienced coder.)
- Formalise clinician engagement to create a Trust-wide formal programme that involved all clinicians and practitioners, such as pharmacists. Create a stakeholder plan and encourage interaction through presentations and detailed coding reviews. Continue regular junior doctor coding awareness presentations.

- Demonstrate that audit recommendations and action plans have been completed in full with more formal and detailed evidence. Revise the original completion date and plan if recommendations have not been met on time.
- Continue to focus the external audits on at least two specialties to verify coding standards as part of an annual audit plan. Verify that previous issues have been corrected by sampling a small volume of FCEs through external audit or departmental checks as appropriate. Include informal audits in the annual audit programme.
- Benchmark coding standards using additional clinical coding quality measures as well as “depth of coding”, such as the national benchmarker, local Trusts’ overall coding data or via specialist data comparison organisations.

# APPENDIX 1 – RECOMMENDATIONS JUNE 2015

| | |
|---|---|
| **Recommendation 1** | Continue to maintain a formal training record for individual coders and an overall training plan for the Clinical Coding Department, including:<br>• ongoing rotation of coding staff responsibilities for different specialties: take steps to avoid the loss of coding quality during transition from one specialty to another;<br>• continued encouragement for coders to work towards clinical coding qualifications; and,<br>• coach experienced coding staff to take over routine management responsibilities. |
| **Responsibility** | Name and job title – Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | Target date for completion: August 2015 - Completed |
| **Comments** | • Continued ongoing rotation of staff - taking into account resource implications and coding quality – all staff when changing specialities, etc. have training from ACC qualified staff who specialise within these specialities. Coding is 100% checked for the first four weeks and then sampled/audited on an on-going basis.<br>• Continued encouragement for coders to work towards clinical coding qualifications: a further two staff to undertake this in September 2015 and another 1 Mar 2016.<br>• All Band 5 staff have responsibility for recording sickness/annual leave and help to facilitate work allocation, etc. to cover annual leave/sickness. |

| | |
|---|---|
| **Recommendation 2** | Update the policy and procedure document promptly as part of the overall annual departmental plan. (The due date could be changed to a date after the expected HSCIC changes.) |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | Target date for completion: August 2015 - Completed |
| **Comments** | Awaiting sign off from Policy Committee in August 2015. Any further comments from Trust, including progress since review. |

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|---|---|
| **Recommendation 3** | Consider setting up a project to review of coding standards, data quality and HRGs to develop understanding between coders, information managers and clinicians. (National coding standards must be retained, which requires the input of a qualified or experienced coder.) |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | *Target date for completion: month year - to be completed by Trust* |
| **Comments** | *Any further comments from Trust, including progress since review* |

| | |
|---|---|
| **Recommendation 4** | Formalise clinician engagement to create a Trust-wide formal programme that involved all clinicians and practitioners, such as pharmacists. Create a stakeholder plan and encourage interaction through presentations and detailed coding reviews. Continue regular junior doctor coding awareness presentations. |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality & Jonathon Odum Medical Director |
| **Priority** | High |
| **Date** | Target date for completion: August 2016 |
| **Comments** | • Presentations are delivered to services/consultants, etc. regarding coding in addition to Junior Doctors Presentations<br>• To discuss and formalise clinician engagement to create a Trust Wide formal programme, etc. Any further comments from Trust, including progress since review |

| | |
|---|---|
| **Recommendation 5** | Demonstrate that audit recommendations and action plans have been completed in full with more formal and detailed evidence.<br>Revise the original completion date and plan if recommendations have not been met on time.<br>Clearly note the date when the initial recommendation was first made |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | Target date for completion: October 2015 |
| **Comments** | To be reviewed |

| | |
|---|---|
| **Recommendation 6** | Continue to focus the external audits on at least two specialties to verify coding standards as part of an annual audit plan. Verify that previous issues have been corrected by sampling a small volume of FCEs through external audit or departmental checks as appropriate. Include informal audits in the annual audit programme. |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | Target date for completion: August 2015 - Completed |
| **Comments** | Issues identified in previous audits are monitored monthly via audits and data quality reports. |

| | |
|---|---|
| **Recommendation 7** | Benchmark coding standards using additional clinical coding quality measures as well as “depth of coding”, such as the national benchmarker, local Trusts’ overall coding data or via specialist data comparison organisations. |
| **Responsibility** | Name and job title - Joanne Cotterell Acting Head of Clinical Coding & Data Quality |
| **Priority** | High |
| **Date** | Target date for completion: August 2016 |
| **Comments** | To review |

# APPENDIX 2 – AUDIT RESULTS 2012 TO 2015

| | IG audit March 2013 | PbR audit April 2013 | Palliative care audit July 2013 | IG Audit Feb 2014 | Coding audit 2014 | Coder audit December 2014 | IG February 2015 |
|---|---|---|---|---|---|---|---|
| Audit areas | Gynae-cology<br><br>General Medicine | Trauma & orthopaed-ics<br><br>A&E | Palliative care | General medicine<br><br>Cardiology | Live / deceased<br>Rehab | Coder level audit - random selection | General surgery |
| Episodes in sample | 200 | 100 | 281 | 200 | 1,054 | 540 | 200 |
| HRG changes | 14 | - | 4 | 7 | 93 | 28 | 7 |
| % episodes changing payment | 7.0 | - | 1.4 | 3.5 | 8.8 | 5.2 | 3.5 |
| Spells tested | 200 | 98 | 200 | 195 | 450 | 528 | 193 |
| % spells changing payment | 3.0 | 7.1 | 1.5 | 7 | 8.0 | 4.9 | 3.6 |
| Pre audit payment[5] | £184,794 | £254,977 | £636,797 | £419,360 | £1,284,785 | £1,031,740 | £375,757 |
| Post audit payment | £186,194 | £260,954 | £641,044 | £419,112 | £1,299,791 | £1,046,526 | £378,611 |
| Gross change | £13,655 | £11,099 | £4,247 | £3,788 | £32,214 | £25,162 | 6,368 |
| % gross change | 5.2 | 4.4% | 0.7 | 0.9 | 2.5 | 2.4 | 1.7 |
| Net change[6] | -£3,859 | £5,977 | £4,247 | - £248 | £15,006 | £14,786 | £2,854 |
| % net change | -1.5% | 2.3 | 0.7 | -0.1 | 1.2 | 1.4 | 0.8 |
| UTA episodes | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

[5] The pre- and post-audit sample is priced using full payment rules but does not local amendments into account such as market forces factor (MFF), non-payment for emergency readmissions, non-elective threshold, and any local agreements.

[6] A positive figure represents an undercharge by the provider.

# APPENDIX 3 – CLINICAL CODING ANNUAL FCES

| Financial Year | Number of FCEs | FCE increase % | WTE required (based on 7,500 FCEs / WTE) | WTE required (based on 8,000 FCEs / WTE) |
|---|---|---|---|---|
| **2006/07** | 109,124 | - | 14.50 | 13.64 |
| **2007/08** | 114,241 | 4.689 | 15.23 | 14.28 |
| **2008/09** | 128,059 | 12.095 | 17.07 | 16.01 |
| **2009/10** | 131,822 | 2.938 | 18.21 | 17.07 |
| **2010/11** | 149,759 | 13.606 | 19.97 | 18.73 |
| **2011/12** | 155,212 | 3.641 | 20.70 | 19.40 |
| **2012/13** | 155,546 | 0.215 | 20.74 | 19.44 |
| **2013/14** | 160,418 | 3.132 | 21.38 | 20.05 |
| **2014/15** | 174,225 | 8.606 | 23.23 | 21.78 |

# APPENDIX 4 – ACTION PLANS 2012/13 TO PRESENT

## 2011-2012 PbR audit recommendations for clinical coding March 2013

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| **Recommendation 1** | **Updates from R2 from 2010/11 review**. The Trust should ensure that the appointment of the three administrator runners' is carried out on a timely basis<br><br>Where appointment are made, the Trust should ensure that these individuals are provided with training in respect of the Connecting for Health (CFH) methodology, in order to increase the accuracy of the case notes which are coded within the Clinical Coding Department. |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | |
| **Date** | Target date for completion: 30/4/2012 |
| **Comments** | Implementation Oct 2012, appointments x 3 have been made and training will be provided as required for role.<br>**Completed** |

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| **Recommendation 2** | Updated from R3 from 2010/11 review. The Trust should ensure that procedures are in place for the introduction of the Royal College of Surgeons' case notes general standards, and that these standards are tailored to the circumstance of the Trust and communicated clearly to coders<br><br>Where actions were previously agreed, but due to changes in personnel these have yet to be implemented, the Trust should ensure there is a timescale in place for the implementation of such action |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | |
| **Date** | Target date for completion: 31/3/2012 |
| **Comments** | Long Term Strategy  Electronic Patient Records<br><br>Implemented as part of OP7 Health Records Policy and also a mandatory training package on intranet that has to be completed for all staff that handle case notes within their role.<br>**Completed** |

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| **Recommendation 3** | Updated from R5 from 2010/11. Upon completion of the procurement of the audit software, the Trust should put in place a programme for the timing of internal auditing to take place on patient records. Where auditing is to be undertaken on a monthly basis, the Trust should consider whether it is possible for this to be undertaken across all inpatient areas, or whether specific areas will be targeted and then revisited on a rolling basis to identify whether improvements have been made<br><br>The results of the auditing undertaken should be routinely reviewed in order for any trends to be identified with the quality and accuracy of the coding, as well as to identify whether any remedial training is required for coders |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | |
| **Date** | Target date for completion: 31/3/2012 |
| **Comments** | Plan in place to implement Audit Software – delayed due to Sickness (Head of Coding) |

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| **Recommendation 4** | Updated from R8 from 2010/11 review. The Trust should ensure that timescales for the production of the revised versions of policies and procedures are adhered to and that these are based on the clinical coding handbooks, which are adapted for specific situations relevant to the Trust. These revised policies should be communicated across the Trust upon completion |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | |
| **Date** | Target date for completion: 31/3/2012 |
| **Comments** | Completed |

## Recommendations from the PbR audit of 2012-13 (April 2013)

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| **Recommendation 1** | Update a review of the 5 cases identified as UTA and provide details of the findings to commissioners instigate a process to address the causes of the UTA episodes |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/06/2012 |
| **Comments** | Implementation of new ways of working - Coding in office from Oct 2012 with the implementation of runners<br><br>All coders to have access to all information related systems during coding process to include Clinical Portal, Euro-king, Radiology system etc.<br><br>See previous comments within PBR Data Assurance Framework follow up<br><br>Completed |

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| **Recommendation 2** | Review all local coding policies and remove those policies that contravene national standards. Update the Trust's Policy and Procedure document regularly |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/03/2012 |
| **Comments** | Completed |

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| **Recommendation 3** | Access to all information related systems to include Euroking, radiology, clinical portal etc.<br><br>Completed<br><br>Recommendation 2 in the 2010/11; R1 in 2009/10; R3 in 2008/09; improve the quality and availability of the coding source documents. Build a system whereby all coding is performed using the complete information for each episode of care |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/06/2012 |
| **Comments** | Implementation of Office based coding to improve the quality and availability of source documents/ systems Oct 2012 – slight delay due to sickness (Head of Coding)<br><br>Access to all information related systems to include Euroking, |

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| | radiology, clinical portal etc.<br>Completed |

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| **Recommendation 4** | Provide feedback and training to coders on the issues noted in this result, including;<br>• The specifics of ophthalmology, particular around cataracts and the rules regarding linking diabetes with specific conditions; and<br>• the extraction of complete and relevant information from case notes;<br>the issues should be followed up as part of the internal audit programmes |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Completed/ ongoing |
| **Comments** | To be linked with peer review.<br>Coders have undertaken additional training (speciality Workshops) for Ophthalmology Coding<br>Completed |

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| **Recommendation 5** | Remind ward and admissions staff of the importance of accurate data for admission methods and lengths of stay, including the effect on HRG assignment |
| **Responsibility** | Name and job title - Health Records Manager |
| **Priority** | Medium |
| **Date** | Target date for completion: 30/04/12 |
| **Comments** | Patient Access Policy (OP39) updated to reflect admission methods and description of use. This is available for all staff to view on the intranet. The list was sent to the manager of the staff that input admission methods and has been raised as an agenda item for the Ward Receptionists meeting<br>Completed |

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| **Recommendation 6** | Undertake a programme of clinical engagement between coders and ophthalmologist to create better understanding of:<br>• Clinical coding requirements generally and for ophthalmology in particular<br>• The detail coding of ophthalmology and commonly related co-morbidities, such as diabetes and<br>• The importance of legible, clear handwriting in coding source documentation to avoid errors |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Completed / on-going |
| **Comments** | On-going - additional meetings arranged with Ophthalmology Consultants |

## 2013-2014 Information governance audit recommendations and action log (July 2013)

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| **Recommendation 1** | Training to take place within the clinical coding department to address any errors which have been highlighted in this audit. These include, but are not limited to:<br><br>Remind staff about the Primary Diagnosis Definition and the fact that the primary diagnostic code must be the main condition treated or investigated in any given episode of care.<br><br>Refresh staff about the appropriate use of codes from Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. (National Clinical Coding Standards ICD-10 4th Edition page XVIII-2)<br><br>Confirm that all staff are aware of the list of mandatory comorbidities as published in Coding Clinic Ref: 88. These must always be coded as they are always considered clinically relevant.<br><br>Clarify the use of ICD-10 code Z74.0 Need for assistance due to reduced mobility. (National Clinical Coding Standards ICD-10 4th Edition Addendum page 132)<br>• |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: See action plan |
| **Comments** | As per action plan |

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| **Recommendation 2** | Appoint to the vacancies as soon as possible. |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Completed / on-going |
| **Comments** | As per action plan |

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| **Recommendation 3** | Motivate staff to undertake the NCCQ (UK) Examination. Clinical Coders who have gone through this examination process have a better understanding of the theory, rules and regulations of coding and are better equipped when assigning clinical codes |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: See action plan |
| **Comments** | As per action plan |

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| **Recommendation 4** | Appoint a Clinical Coding Auditor in order to commence a programme of regular audits which would identify any repeated coding errors such as those found in this audit. |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: See action plan |
| **Comments** | As per action plan |

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| **Recommendation 5** | Consultant validation must be addressed across all areas and all specialties, not just for mortality coding. |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: See action plan |
| **Comments** | As per action plan |

## 2014-2015 Information governance audit recommendations and action log

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| **Recommendation 1** | Training to take place within the clinical coding department to address any errors which have been highlighted in this audit. These include, but are not limited to:<br><br>Remind staff about the importance of correct indexing including verifying the code in the Tabular List.<br><br>Refresh staff regarding the correct coding of a PR Bleed.<br><br>Confirm all staff are aware of the list of mandatory comorbidities as published in *Coding Clinic Ref: 88.*<br><br>Discuss the correct use of site codes on endoscopic procedures.<br><br>-To be undertaken as soon as possible, definitely within three months.<br><br>Ensure that histologies are always checked and the coding amended when appropriate.<br><br>-As soon as possible but definitely within the next month |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/05/2014 |
| **Comments** | Reminder to all staff regarding coding indexing – further discussion took place in team governance meetings<br><br>Training given to staff members regarding coding of PR Bleed, correct use of site codes on endoscopic procedures and the importance of ensuring histologies are checked<br><br>Comorbidities Information given to all staff<br><br>**Completed** |

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| **Recommendation 2** | Investigate as a matter of urgency the possibility of restructuring the department to include a team leader and an auditor as a minimum and possibly a trainer. Whilst the staff have no incentive to move upwards within the department it will remain difficult to recruit and retain trained, qualified clinical coding staff |
| **Responsibility** | Name and job title - Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/07/2014 |
| **Comments** | Restructure Implemented to include auditor, Band 5 ACC Coders, trainees, team Managers - ongoing -<br>**Completed Jan 2015** |

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| **Recommendation 3** | Appoint to the vacancies as soon as possible as currently the coders are expected to code an excessive number of episodes each |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/06/2014 |
| **Comments** | Restructure Implemented to include auditor, Band 5 ACC Coders, trainees, team Managers - ongoing - additional staff employed from August 2014<br>**Completed Jan 2015** |

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| **Recommendation 4** | Motivate staff to undertake the NCCQ (UK) Examination. Clinical Coders who have gone through this examination process have a better understanding of the theory, rules and regulations of coding and are better equipped when assigning clinical codes.<br>Although study is encouraged, the Trust must investigate the possibility of an incentive to motivate staff towards studying for this qualification. To be addressed within six months. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/06/2014 |
| **Comments** | 3 staff members have undertaken the ACC.<br>ACC Qualified Coders have now been re-banded to Band 5 but role also has additional responsibility etc.<br>**Completed** |

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| **Recommendation 5** | Commence a programme of regular audits which would identify any repeated coding errors such as those found in this audit.<br>-This must be an ACC qualified member of staff who should be supported in gaining this qualification through attending an NHS Classifications Service Auditor Workshop, hopefully within the next year. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/04/2014 |
| **Comments** | Implemented from April 2014 – more audits will be conducted following the employment of additional staff – audit timetable implemented<br>**Completed** |

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| **Recommendation 6** | Discuss with clinicians in the Cardiology specialty the necessity for clear and complete documentation showing all relevant diagnoses as well as any procedures undertaken.<br>-As soon as possible, definitely within three months. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Completed |
| **Comments** | Meeting conducted with CD and Head of service - to be reviewed in October 2014 |

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| **Recommendation 7** | Consultant validation must be addressed across all areas and all specialties, not just for mortality coding<br>-To commence as soon as possible but definitely before next year's IG Audit. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Completed |
| **Comments** | |

## 2015-2016 Information governance audit recommendations and action log

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| **Recommendation 1** | Training to take place within the clinical coding department to address any errors which have been highlighted in this audit. These include, but are not limited to:<br>Remind staff about the importance of correct indexing including verifying the code in the Tabular List.<br>Refresh staff regarding the correct coding of a PR Bleed.<br>Confirm all staff are aware of the list of mandatory comorbidities as published in *Coding Clinic Ref: 88.*<br>Discuss the correct use of site codes on endoscopic procedures.<br>• To be undertaken as soon as possible, definitely within three months.<br>Ensure that histologies are always checked and the coding amended when appropriate.<br>As soon as possible but definitely within the next month. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/05/2015 |
| **Comments** | Reminder to all staff regarding coding indexing – further discussion took place in team governance meetings<br>Training given to staff members regarding coding of PR Bleed, correct use of site codes on endoscopic procedures and the importance of ensuring histologies are checked<br>Comorbidities Information given to all staff<br>**Completed** |

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| **Recommendation 2** | Discuss with clinicians the necessity for clear and complete documentation showing all relevant diagnosis as well as any procedures undertaken |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: 30/07/2015 |
| **Comments** | On-going |

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| **Recommendation 3** | Investigate why the Portal runs so slowly and is at times unstable as this is impacting on the work of the coding department and the amount of time it takes to code episodes. |

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| **Responsibility** | Name and job title - Head of IT Development |
| **Priority** | High |
| **Date** | Target date for completion: 30/05/2015 |
| **Comments** | Portal Has been upgraded – speed has been addressed – **Comped** June 2015 |

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| **Recommendation 4** | Although staff numbers within the department has greatly improved it is important that if activity increases then clinical coding staff numbers must continue to be increased proportionately. |
| **Responsibility** | Name and job title - Acting Head of clinical coding and data quality |
| **Priority** | High |
| **Date** | Target date for completion: Ongoing |
| **Comments** | Recruitment Plan for 15-16 = 2 additional trainees and 1 WTE Band 5 Coder – advertise June 2015 |