Archwilio Cymru
Audit Wales

Clinical Coding Progress Review

Cardiff and Vale University Health Board

April 2026

We have prepared and published this under section 61 of the Public Audit Wales Act 2004.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

- call us on 029 2032 0500
- email us at info@audit.wales

You can use English or Welsh when you get in touch with us – we will respond to you in the language you use.

Corresponding in Welsh will not lead to a delay.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot

What we looked at

1 This review assessed Cardiff and the Vale University Health Board's (the Health Board) progress in implementing recommendations from our 2014 and 2019 reviews of clinical coding. We also examined the actions the Health Board is taking to improve clinical coding performance.

Why this is important

2 Clinical coding converts information about a patient's care into standardised national and international codes, which are used for both inpatient and outpatient care. These codes support hospital funding, service planning, performance monitoring, clinical audit, and assessments of quality and effectiveness. Accurate and timely clinical coding, therefore, is essential for effective patient care and the efficient running of health services.

3 Our 2014 Review of Clinical Coding found that although the Health Board showed a strong commitment to clinical coding, weaknesses in management arrangements, medical records, and engagement with clinical staff were affecting performance. Our 2019 Follow-up Review found improvements in data quality and its use, but concluded that further work was needed to fully address our 2014 recommendations. Of the 25 recommendations made in 2014, 16 remained outstanding in 2019, and we made one new recommendation (see **Appendix 2**).

What we have found

4 The Health Board has made some progress since our last follow-up review, but many long-standing issues remain.

5 Workforce stability within the Clinical Coding Team has improved supported by clearer management arrangements and staff development opportunities. Staff also report a supportive team culture. However, significant senior vacancies remain, and key activities such as validation, audit and training still depend on a small number of individuals. The Clinical Coding Policy and Procedure Manual is outdated and no longer reflects current operational arrangements.

6 Medical records continue to be a major barrier to timely and accurate clinical coding. Although the use of temporary records has reduced and access has improved in some areas, problems persist with record quality, delays in collation, inconsistent tracking and continued reliance on paper records.

7 Board awareness of clinical coding has been maintained and there is a commitment to improvement. However, oversight is limited with reporting focusing narrowly on Welsh Government targets. There is little explanation of the use of coded data and committee oversight is unclear. While the Clinical Coding Team's visibility has improved, clinical engagement remains limited.

8 The Health Board's performance against Welsh Government clinical coding measures and targets has not shown sustained improvement and continues to fluctuate over time. While a range of actions are underway, there is no clear, coordinated plan to drive and sustain long-term improvement.

What we recommend

9 We have made six new recommendations, which replace all outstanding recommendations from our 2014 and 2019 reviews. The recommendations focus on:

- improving shared learning and collaboration between the two clinical coding teams;
- updating the Clinical Coding Policy and Procedure Manual, with a focus on shared responsibility between the coding team and clinical services;
- improving Board visibility and understanding of clinical coding;
- introducing a business partnering model to strengthen clinical engagement; and
- developing a clinical coding plan to address current and future challenges.

Key facts and figures

Of the 17 outstanding recommendations from our 2014 and 2019 reviews, three are complete, three are in progress, and limited progress has been made on 11. We have superseded all outstanding recommendations with new recommendations.

In December 2025, only 66.3% of episodes were coded within one month of a patient being discharged, well below the 95% target. Cardiff and Vale University Health Board was the lowest performing health board in this measure across Wales at the time.

In February 2026, only 21.8% of coding errors were corrected by the next monthly reporting deadline, well below the 90% target.

General medicine, midwifery and paediatric services recorded the most uncoded episodes.

The Clinical Coding Team currently has eight senior vacancies – a Clinical Coding Manager, a Training and Compliance Manager, and six Senior Clinical Coders.

Our findings

Implementation of previous recommendations

Despite taking some positive steps to improve the service, a number of issues remain unresolved, which continue to affect performance and assurance

Clinical coding resources

10 Our previous reviews highlighted weaknesses in the management, stability and supervisory capacity of the clinical coding team. Since then, the Health Board has finalised its clinical coding team structure, and management arrangements are clearer. In September 2023, the team also moved from the Digital and Health Intelligence Directorate to the Clinical Diagnostics and Therapeutics Clinical Board. This change was intended to raise the profile of clinical coding and provide clearer governance, structure, and oversight.

11 The creation of an Assistant Clinical Coding Manager in 2025 has reduced some operational pressures previously absorbed by the Head of Clinical Coding. However, many other senior posts intended to provide oversight and supervision remain vacant (see **Exhibit 1**). These include the Clinical Coding Manager role, the Trainer and Compliance Manager role, and six of the seven Senior Clinical Coder roles. As a result, management capacity within the team remains limited, which constrains its ability to focus on strategic planning, service improvement, and collaborative working. This situation reduces service resilience and increases the risk of further deterioration in performance.

Exhibit 1: roles and vacancies in the clinical coding team

	Number of posts in structure	Number of vacancies
Head of Clinical Coding	1	0
Clinical Coding Manager	1	1
Assistant Clinical Coding Manger	1	0
Trainer and Compliance Manager	1	1
Senior Clinical Coder	7	6
Clinical Coder	7	0
Coding Trainee	11	0
Support Officer	4	0
Total	**33**[1]	**8**

Source: Data provided by Cardiff and Vale University Health Board

12 Effective clinical coding relies on robust validation and quality assurance arrangements. While routine checks are carried out, particularly for work completed by trainee coders, these arrangements are largely informal, relying on a small number of experienced staff with limited capacity. The Health Board was planning to recruit an accredited Clinical Coding Auditor and a Trainer and Compliance Manager. However, due to recruitment challenges, these posts remain vacant. The Health Board plans to assess the feasibility of recruiting to these roles as part of the team's workforce review. This means that validation processes are not yet stable or consistent, limiting assurance over data quality.

[1] The total clinical coding Full Time Equivalent (FTE) is 32.46.

13 Recruiting and retaining clinical coding staff remains challenging. The Health Board has lost a number of staff to English NHS Trusts as they offer higher pay, operate digital medical records, and provide greater homeworking opportunities for coders. The Health Board has taken steps to address this, including investing in agency staff to support with backlog work. As a result, workforce stability has improved and staff now report a supportive team culture, improved flexible working, and a clearer management structure. Staff were also positive about the team's move into the Clinical Diagnostics and Therapeutics Clinical Board. However, if senior vacancies remain unfilled, the team will continue to lack the capacity needed to cope with pressures and make lasting improvements. This risks undermining the sustainability of recent progress.

Staff training and development

14 Our 2019 follow-up review found several weaknesses in staff training and development. These included coders not being rotated across specialties, a lack of clarity about training and induction, and coding teams not having regular meetings to share learning.

15 Since then, the Health Board has made some improvements. It has adopted a 'grow your own' approach to developing coding staff and has introduced a new internal clinical coding qualification, which four coders have completed so far. Several other team members are also interested in completing the qualification to support their career progression. The team has also developed a mentoring culture, with support available beyond trainee coders. The Health Board has also reviewed how specialties are allocated across the team. This has helped broaden experience and improve cover when staff are absent. Coders who took part in our focus group described a supportive and collaborative team, with good opportunities for progression.

16 However, these opportunities are constrained by limited team capacity. Training, mentoring and support rely heavily on a small number of experienced coders, and arrangements remain largely informal. This reliance on a small number of experienced coders limits the consistency and scalability of training and development arrangements. There is an opportunity, therefore, to clarify and formalise expectations for training and development, including mentoring arrangements and rotation between specialties, by updating the Clinical Coding Policy and Procedure Manual (see **paragraph 20**).

17 The Health Board's plan to recruit a Clinical Coding Trainer and Compliance Manager is under review. Staff consider this role to be critical to strengthening training arrangements and improving the team's overall performance.

18 Clinical coding is carried out by two separate teams, one at University Hospital of Wales (UHW) and the other at University Hospital Llandough (UHL), both managed by the Head of Clinical Coding. Although the teams work independently, there is some collaboration. However, they do not hold joint team meetings, and there is scope to create more formal opportunities to share learning and standardise practice.

Policy and procedure

19 Our 2019 review found that the Health Board had not updated its Clinical Coding Policy.

20 Since then, the Health Board has issued a new Clinical Coding Policy and Procedure Manual in November 2021. However, the Clinical Coding Policy and Procedure Manual has not been reviewed and updated since November 2022. The policy and manual, therefore, are out of date and no longer reflect current management arrangements or the revised structure of the Clinical Coding Team. As a result, it does not provide a clear or reliable reference for staff or the services the team works with.

21 Updating the policy and procedure provides an opportunity to clarify how clinical coding works. The revised policy and procedure should clearly set out the roles, responsibilities and expectations of the clinical coding team and clinical services. This would support more consistent practice, clearer accountability and more effective working arrangements across the Health Board. Once updated and approved, the policy and procedure should be clearly communicated to all clinical services.

Medical records

22 Our 2019 follow-up review found that ongoing problems with medical records continued to affect the timeliness and accuracy of clinical coding. These issues included the use of temporary records, difficulties tracking case notes, poor record quality, and delays in accessing records, including the Teenage Cancer Unit.

23 Since then, the Health Board has made some improvements. The use of temporary medical records has reduced, and access to Teenage Cancer Unit records has improved. The relocation of the Clinical Coding team to UHW has also improved access to paper records.

24 However, the quality and availability of medical records continue to present a significant barrier to timely and accurate clinical coding. Records remain largely paper-based, and coders continue to experience delays due to missing documentation, poor handwriting, mixed-up patient notes, and storage pressures. Delays in collating medical records, linked to the limited capacity of the collating team, contribute to backlogs and slow the coding process.[2] In some cases, wards request records back before coding is complete, further delaying completion.

[2] Collating medical records is the process of bringing together all documents for a patient's episode of care into one complete, organised record, so they can be used for care, record management, and clinical coding.

25 The quality of medical records remains inconsistent, and the Health Board does not have a clear system in place to routinely monitor the quality of records. It has not adopted the Royal College of Physicians' standards for medical record keeping nor has it trained clinical staff on the importance of good quality records and its wider impacts.

26 The Clinical Coding Team uses the Patient Administration System (PAS) to track medical records, but use of the system is inconsistent across services. In some cases, records are not added to PAS until they reach the Clinical Coding Team, limiting visibility and delaying coding. These issues are partly due to limited training and the use of multiple digital systems alongside PAS.

27 The completion of discharge summaries also remains inconsistent and continues to constrain timely and accurate clinical coding. Some discharge summaries are incomplete when sent for coding, while others are not completed at all. Operational pressures on clinical staff and the use of multiple digital systems, including electronic discharge summaries, may be contributing factors.

28 Greater digitisation would improve patient care and support clinical coding by making medical records clearer, more complete and easier to access. Indeed, the Health Board's long-term strategy commits the organisation to become fully paperless by 2035.[3] However, while some services, including maternity and ophthalmology, have begun to digitise their records, progress has been slow, and most medical records remain paper-based. We are currently carrying out a separate review of digital transformation at the Health Board and will comment separately on Electronic Records Management as part of that work.

Board engagement

29 Our 2019 follow-up review found that the Board had a good awareness of clinical coding and received regular performance information. However, further work was needed to improve understanding of how clinically coded data is used.

---

[3] Shaping Our Future Wellbeing Strategy

30 The information the Board receives on clinical coding is generally limited to the two Welsh Government targets reported through the Integrated Performance Report (see **paragraphs 28 and 30**). However, the report provides little explanation of why performance is improving or deteriorating, how coded data is used, or whether current actions are having an impact on service improvement. This limits the Board's ability to understand the causes of underperformance or assess whether current actions are delivering improvement.

31 Board level oversight for clinical coding is unclear. It is not clear which committee is responsible for monitoring performance, providing challenge, and driving improvement. While clinical coding is sometimes discussed by the Digital and Infrastructure Committee, this is not consistent, and there is no routine report focused specifically on clinical coding.

32 Although the 2025-26 Annual Plan identifies improving clinical coding as a key priority within the Health Board's Shaping Our Future Infrastructure portfolio, there is currently no overarching improvement plan for clinical coding (see **paragraph 33**). This makes it difficult for the Board to track progress or gain assurance that key issues, such as workforce capacity, quality of medical records, and clinical engagement, are being addressed appropriately and effectively.

Clinical engagement

33 Our 2019 review found that more needed to be done to involve clinical staff in the clinical coding process. We highlighted the need for ongoing training to improve their understanding of clinical coding and their role in supporting good quality data.

34 There is little evidence that clinical staff receive regular training on the importance of clinical coding or how their records affect coding quality and performance. Clinical staff are also not routinely involved in coding validation or review activities, limiting opportunities to improve data quality and shared learning.

35 There is no clear or coordinated approach to support wider clinical engagement across the Health Board. While the relocation of the Clinical Coding Team to UHW has improved visibility, routine engagement with clinical services remains limited. While some early collaborative work is underway with individual specialties, such as stroke services, this activity is ad hoc and constrained by capacity. To make sure there is structured and sustainable engagement with clinical services, the coding team should implement a business partnering model or similar.

Performance and improvement

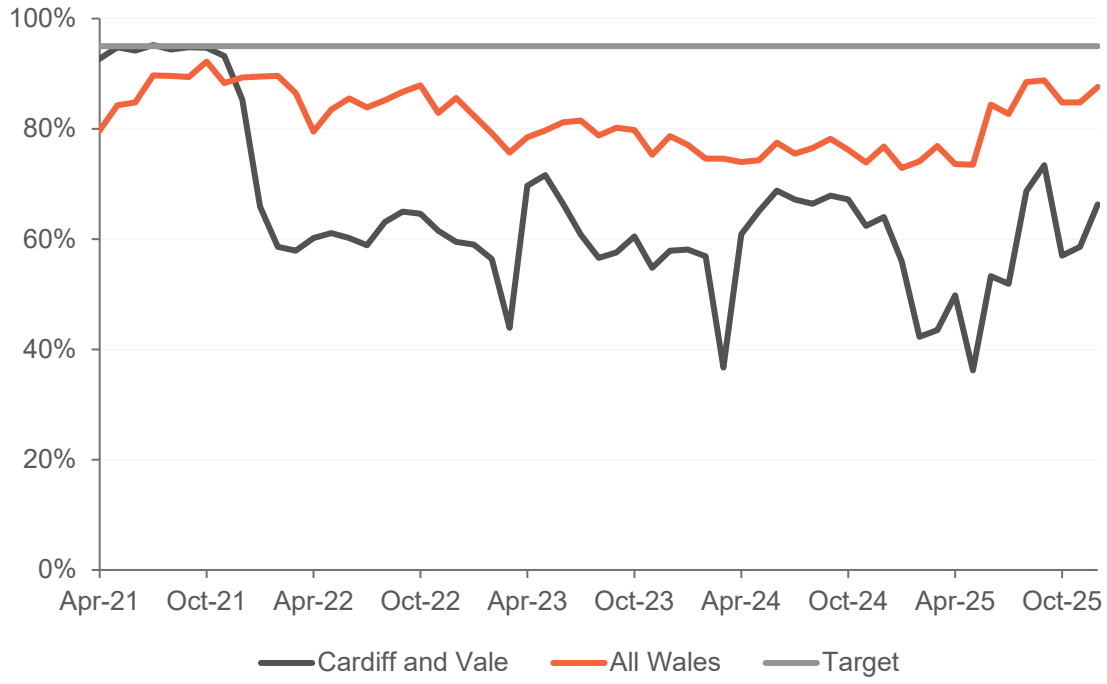
The Health Board has consistently missed Welsh Government targets for clinical coding completeness and accuracy and urgently needs a coordinated plan for improvement

Clinical coding performance

36 Despite the progress the Health Board has made in addressing some our previous recommendations, the improvements do not seem to have had a noticeable impact upon its clinical coding performance.

37 The Welsh Government has set two performance measures and targets for clinical coding. The first measure is that all health bodies must complete clinical coding for each patient episode within one month of the patient's discharge, with a target of 95%. **Exhibit 2** shows that the Health Board is not meeting this target. Performance fell after November 2021 and has since remained variable and consistently below both the target and the Wales average.

Exhibit 2: percentage of all episodes coded within one month of the episode end date

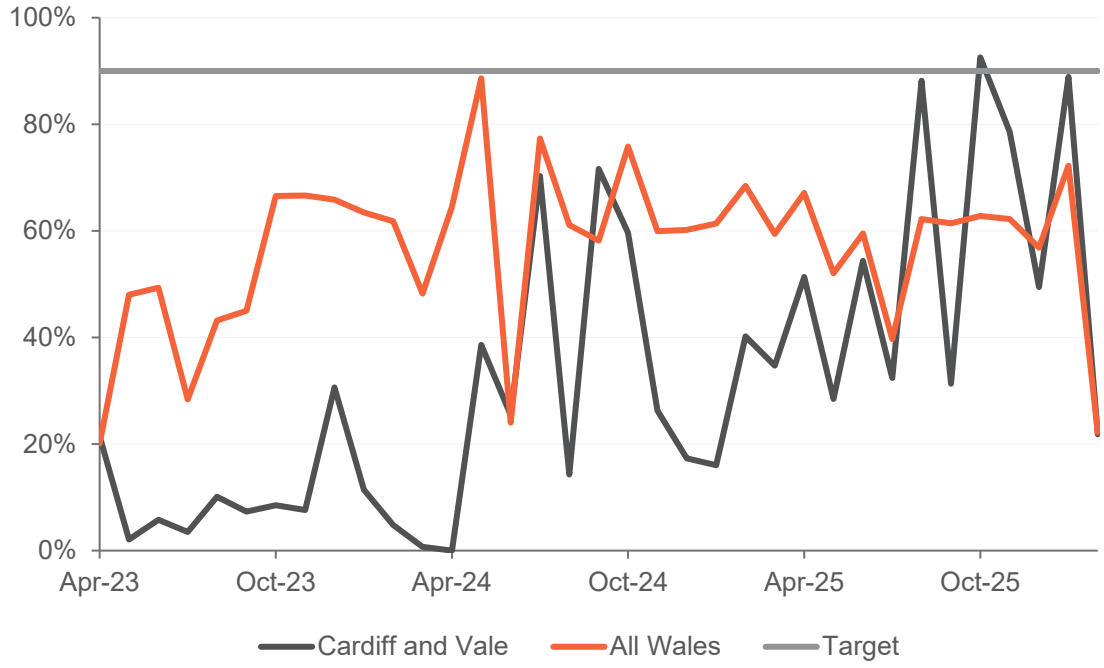


Source: Audit Wales analysis of Digital Health and Care Wales data

38 In 2024-25, there were 30,223 uncoded episodes, which was 19% of all episodes. By November 2025, this had increased to 34,738 uncoded episodes, representing 34% of the total. This is a significant rise (15%) from the previous year. Most of the uncoded episodes were in general medicine, midwifery, and paediatric services.

39 The second measure is that all health bodies must correct any coding errors by the time they submit their next monthly report, with a target of 90%. **Exhibit 3** shows that the Health Board's performance against this measure is inconsistent and remains well below target. Although there are occasional improvements, they are not sustained and usually followed by a sharp decline. Between April 2023 and February 2026, the Health Board met the target only once and its performance is generally below the Wales average.

Exhibit 3: percentage of clinical coding errors corrected within 35 days



Source: Audit Wales analysis of Digital Health and Care Wales data

40 The reasons for underperformance are well understood by the Health Board, and include many of the challenges noted earlier, such as recruitment and retention, management capacity, the quality of medical records, and clinical engagement. However, as noted previously, the Health Board should do more to explain this underperformance to Board.

Actions to improve performance

41 The Health Board has shown a clear commitment to improving clinical coding performance and has already taken some positive steps as noted earlier. The 2025-26 Annual Plan also commits the Health Board to developing a Sustainable Clinical Coding Plan. Planned actions include:

- developing a plan for paperless medical records;
- moving to digital only coding for cataract surgery;

- exploring a move to digital coding options, and
- developing a sustainable workforce and training plan.

42 However, we found no evidence that these actions have been brought together yet into the single, fully developed Sustainable Clinical Coding Plan set out in the Annual Plan. While the team has improvement plans for individual projects, the absence of an overarching plan makes it difficult to understand the short and long-term improvement aims for the service, the associated financial and workforce requirements, and how progress will be monitored.

43 Furthermore, most of the planned improvements depend on investment in digital systems. The Health Board's five-year Digital Strategy, which includes clinical coding, is now outdated. Although the strategy is due to be updated, the Clinical Coding Team has not yet been involved. It is important that the digital and clinical coding teams work together to ensure the updated Digital Strategy and Clinical Coding Sustainability Plan align and support each other.

Recommendations

We have made six new recommendations, which replace all outstanding recommendations from our 2014 and 2019 reviews (see **Appendix 2**).

R1 To help shared learning, the two coding teams, based at UHW and UHL, should hold regular team meetings. (**Paragraph 18**)

R2 The Health Board should update its Clinical Coding Policy and Procedure, emphasising shared responsibility for clinical coding. For example, by setting out:

- clinical coding team responsibilities;
- clinical services responsibilities;
- expectations for:
  - the quality of clinical documentation;
  - the availability and tracking of medical records;
  - use of systems such as the Patient Administration System;
  - training and development of coding and clinical staff; and
  - engagement arrangements between the coding team and services. (P**aragraph 20**)

R3 To help the Board better understand clinical coding performance, the Health Board should clearly explain, in the Integrated Performance Report, the main factors affecting clinical coding performance. (**Paragraph 21**)

R4 To show how clinical coding data is used, the Health Board should clearly identify in Board and committee papers when coded data has been used to support planning, performance monitoring, or decision-making. (**Paragraph 21**)

R5 To strengthen clinical engagement, the coding team should introduce a business partnering approach, or a similar model. (**Paragraph 26**)

R6 The Health Board should develop its Sustainable Clinical Coding Plan to address current and future challenges. The Health Board should ensure the plan:

- is costed, at a minimum, for the medium term (3-5 year);
- is supported by a workforce plan, including a plan to reduce use of agency staff;
- developed with clinical services;
- aligns with the digital strategy;
- includes clear milestones and performance trajectories; and

- ensure an appropriate committee receives regular progress updates.

The Health Board should also ensure that the Sustainable Clinical Coding Plan addresses the actions detailed in Recommendations 1-5 above. (**Paragraph 33**)

Appendices

1 About our work

Scope of the audit

We have assessed whether the Health Board has implemented the Auditor General's recommendations in full to improve clinical coding arrangements and performance.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Health Board implemented all outstanding recommendations from the 2014 Review of Clinical Coding and the new recommendation made in the 2019 Clinical Coding Follow-up Review?
- Does the Health Board have a clear plan and accountability arrangements in place to improve clinical coding performance?
- Is the Health Board's performance against Welsh Government targets for timely and accurately coded data improving?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it had:

- made the expected progress in implementing our 2014 and 2019 audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the audits; and
- plans in place to improve clinical coding performance.

Methods

We undertook our audit work between November 2025 and February 2026.

We reviewed the following key documents:

- Annual Plan 2025-2026;
- 5 Year Digital Strategy;
- Integrated Performance Reports;
- DHCW clinical coding performance dashboards;
- Public Board papers;
- Quality Committee papers;
- Strategic Leadership Team meeting papers;
- Public Digital and Infrastructure Committee papers;
- Digital Health and Intelligence Committee papers;
- Clinical coding project and workforce plans;
- Policies and procedures; and
- Training resources.

We interviewed the following:

- Chief Operating Officer
- Directorate Manager for the Clinical Diagnostics and Therapeutics Clinical Board
- Director of Operations for Clinical Diagnostics and Therapeutics
- Head of Clinical Coding
- Assistant Clinical Coding Manager
- Clinical Lead for Stroke and Neurologist

We also facilitated a focus group with a selection of clinical coding staff.

2 Previous recommendations

The table below shows the Health Board's progress against recommendations from our 2014 and 2019 reviews. All outstanding recommendations from those reviews have been replaced by new recommendations on **page 19**.

Clinical Coding Resources (2019)

R1 Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity (**complete, see paragraph 10**).

Clinical Coding Resources (2014)

R1 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include:

c) ensuring that there is capacity to allow Band 4 Coders to undertake mentoring and checking of coding of Band 3 staff in line with job descriptions (**in progress, see paragraph 15**);

d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years (**in progress, see paragraph 15**);

g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge (**limited progress, see paragraph 18**);

h) updating the clinical coding policy to reflect the current operational management arrangements (**limited progress, see paragraph 19**), and

k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited Clinical Coding Auditor (**limited progress, see paragraph 12**).

Medical Records (2014)

R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:

a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards (**limited progress, see paragraph 25**);

b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS) (**limited progress, see paragraph 26**);

c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW (**limited progress, see paragraph 24**);

e) reducing the level of temporary medical records in circulation (**complete, see paragraph 23**);

f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders (**complete, see paragraph 23**); and

g) revisiting the availability of training on the importance of good quality medical records to all staff (**limited progress, see paragraph 25**).

Board Engagement (2014)

R3 Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include:

c) raising the awareness amongst Board members of the wider business uses of clinically coded data (**limited progress, see paragraph 21**).

Clinical Engagement (2014)

R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:

a) reinforcing the importance of completing discharge summaries to aid the coding process (**limited progress, see paragraph 27**);

b) ensuring that clinical staff receive an appropriate level of on-going training with regards to the process and purposes of clinical coding, outside of initial junior inductions (**limited progress, see paragraph 25**);

c) establishing validation processes that involve clinical staff, which will act to both improve clinical engagement and act as a form of accuracy review (**limited progress, see paragraph 25**); and

d) improving the 'visibility' of coding staff, to ensure that clinical engagement operates as a two-way process (**in progress, see paragraph 26**).

3 Key terms in this report

Term	Description
Discharge summary	A clinical document completed when a patient leaves hospital, which summaries the patient's care during that hospital stay.
Electronic Patient Record (EPR)	Is a computer-based record of a patient's health and care, which replaces or supplements paper medical notes.
Integrated Performance Report	A regular Board-level report that brings together information on quality, performance, finance and workforce to provide a single, joined-up view of how the organisation is performing.
Patient Administration System (PAS)	A core administrative IT system used to record, track and manage patient activity.
Patient episode	A patient episode (or episode of care) is a defined period of treatment or service provided to a patient, starting from a referral and ending at discharge.
Royal College of Physician (RCP) standards	National professional standards that define how patient records should be structured, completed and maintained to ensure safe, high-quality care.
Validation	The process of verifying that data recorded is correct and reflects the patient's care pathway.

4 Mangement response

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	To help shared learning, the two coding teams, based at UHW and UHL, should hold regular team meetings.	The Head of Clinical Coding, alongside existing site-based team meetings, will introduce joint team meetings. The frequency will be bi-monthly, with meetings held predominantly via MS Teams. Where practical, bi-annual face to face meetings will take place.	May 2026	Head of Clinical Coding
R2	The Health Board should update its Clinical Coding Policy and Procedure, emphasising shared responsibility for clinical coding. For example, by setting out: • clinical coding team responsibilities; • clinical services responsibilities; • expectations for:	The Health Board will revise its Clinical Coding Policy and Procedure to include all the elements specified in the report. Consultation with the National Standards team will be undertaken, and the updated policy will be presented through established Health Board governance channels for approval.	July 2026	Directorate Manager, Clinical Coding, Outpatient Nursing & Patient Administration

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	– the quality of clinical documentation; – the availability and tracking of medical records; – use of systems such as the Patient Administration System; – training and development of coding and clinical staff; and – engagement arrangements between the coding team and services			
R3	To help the Board better understand clinical coding performance, the Health Board should clearly explain, in the Integrated Performance Report, the main factors affecting clinical coding performance.	The Integrated Performance Report will include details of clinical coding performance, including the main factors affecting clinical coding performance.	June 2026	Director of Operations, Clinical Diagnostics and Therapies

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R4	To show how clinical coding data is used, the Health Board should clearly identify in Board and committee papers when coded data has been used to support planning, performance monitoring, or decision-making.	The Health Board will strengthen the visibility of clinical coding data within Board and committee reporting arrangements. As part of the development of the 2026/27 performance and assurance framework, report templates and author guidance will be reviewed to require explicit reference to where clinical coding data has informed planning, performance monitoring, service improvement, or decision-making. This will initially be implemented through key corporate and operational reporting routes, with oversight from the Executive Team, and will support a more consistent approach across departments. Arrangements will be reviewed during 2026/27 to ensure the use of clinical coding intelligence is routinely evidenced and clearly communicated at Board and committee level.	January 2027	Chief Operating Officer
R5	To strengthen clinical engagement, the coding team should introduce a business partnering approach, or a similar model.	The clinical coding service is currently facing significant workforce challenges. There is an ongoing reliance on external coders, paired with a shortage of senior clinical coders within the department. Due to these constraints, the service	January 2027	Head of Clinical Coding

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		must maintain a centralised operational model. Leadership and engagement with clinical boards and clinicians therefore falls to the senior managers and the coding manager, who continue to guide and support collaborative efforts with clinical teams. The department will keep the current approach under ongoing review. As the workforce situation improves in the future, there are plans to transition to a business partner model. This would involve assigning senior clinical coders to individual clinical boards, thereby strengthening direct clinical engagement and support. Based on current recruitment, training and development plans, CAV is unlikely to have enough senior coders to fully implement a business partnering model for around 18 months. This position will be kept under regular review.		
R6	The Health Board should develop its Sustainable Clinical Coding Plan to address current and future challenges. The Health Board should ensure the plan:	**Development of the SCCP** The Health Board is committed to developing a comprehensive and adaptive Sustainable Clinical Coding Plan (SCCP). This plan will address all required aspects. A Strategic Workforce Plan for Clinical Coding covering a 3-5 year period will be	September 2026	Director of Operations, Clinical Diagnostics and Therapies

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	• is costed, at a minimum, for the medium term (3-5 year); • is supported by a workforce plan, including a plan to reduce use of agency staff; • developed with clinical services; • aligns with the digital strategy; • includes clear milestones and performance trajectories; and • ensure an appropriate committee receives regular progress updates. The Health Board should also ensure that the Sustainable Clinical Coding Plan addresses the actions detailed in Recommendations 1-5 above.	further developed. This workforce plan will incorporate indicative costing models to ensure future sustainability and strategic planning. **Alignment with Recommendations** The SCCP will be designed to include and align with the plans and commitments associated with Recommendations 1 to 5. This integration will ensure a cohesive approach, linking the SCCP to existing and forthcoming initiatives within the Health Board.		

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.