NHS
Isle of Wight
NHS Trust

DATA QUALITY POLICY

Document Author	Authorised
Written By: Deputy Director of Information **Date:** 17/10/2019	**Authorised By:** Chief Executive **Date:** 15th November 2019
Lead Director: Director of Finance, IM&T & Estates	
Effective Date: 15th November 2019	**Review Date**: 14th November 2022
Approval at: Policy Management Sub-Committee	**Date Approved:** 15th November 2019

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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
29 Aug 12	2.1			Includes updates from Ben Dearden, Sarah Sharp, James Potter-Irwin, Tracy Asher, Mark Price & Tony Martin	
14 Sep 12	2.2			Feedback and ratified by	IG Steering Group to progress to Executive Board
26 Nov 12	2.3			Final Draft	
03 Dec 12	2.4			Updated Format	
Dec 12	2.5			Policy approved by	Risk Management Committee and Policy Management Committee
07 Jan 13	3.0	07 Jan 13		Approved at	Trust Board
	3.1		Executive Director of Financial and Human Resources	Minor changes to update content, updated to new policy template, addition of data quality framework as an appendix as agreed by	Information Governance Steering Group
	3.2		Executive Director of Financial and Human Resources	Amendments requested	Risk Management Group
	3.3		Executive Director of Financial and Human Resources	Voting buttons for Approval	Risk Management Group
19 Jan 16	4.0	19 Jan 16	Executive Director of Financial and Human Resources	For Approval	Policy Management Group
		8 Sept 16	Executive Director of Financial and Human Resources	For Approval	Information Steering Group
11 Oct 16	5.0	11 Oct 16	Executive Director of Financial and Human Resources	For Approval	Corporate Governance and Risk Sub Committee
Sep 2019	5.1		Director of Finance, IM&T and Estates	Policy review	
05 Sep 19	5.1		Director of Finance, IM&T and Estates	Endorsed at	Information Governance Sub-Committee
15 Nov 19	6.0	15 Nov 19	Director of Finance, IM&T and Estates	Approved via voting buttons at	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

A vital pre-requisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. The organisation requires high quality data to support a number of business objectives, including safe and effective delivery of care, and the ability to demonstrate the achievement of key performance indicators.

This policy identifies the dimensions of data quality, which must all be observed in order to ensure that data is of a consistently high quality. The fundamental principle of data quality is that data should be right first time, which means that the responsibility is held at the point at which it is collected and recorded, whether the person recording the information is clinical, technical or clerical. It also means that all information systems should be implemented and configured in such a way as to ensure they are fit for purpose

It is important to note that the scope of this policy includes both paper and electronic records, and covers all data created by the organisation, whether that relates to patients, to staff or to other subjects, for example:-

- Finance and income
- Information governance
- Patient safety
- Performance and statistics
- Operational efficiency
- Human resource management

This policy sets out the specific roles and responsibilities of staff and management in ensuring that data is managed effectively from the point of collection, through its lifecycle until disposal.

Compliance with individual responsibilities is required by the Public Records Act (1958). Any issue relating to individual capability or conduct should be dealt with through the relevant procedure.

This policy sets out the Trusts data quality framework, which sets out the processes and procedures employed by the Trust to ensure the quality of its data.

2 Introduction

The Trust is committed to ensuring the quality of its data, in order to promote effective decision making and patient safety.

High quality information means better patient care and patient safety, and there could be potentially serious consequences if information is not correct and up to date, both for patients and for the Trust as a whole.

Management information produced from patient data is essential for the efficient running of the Trust and to maximise utilisation of resources for the benefit of patients and staff. It supports making effective decisions about the deployment of resources, and also in demonstrating the value of the services provided by the Trust.

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The Trust requires accurate, timely and relevant patient information in order to support:

- The delivery of effective, safe patient care
- The delivery of its core business objectives
- The monitoring of activity and performance for internal and external management purposes
- Clinical governance and clinical audit
- Service agreements and contracts
- Healthcare planning
- Accountability
- Compliance with Data Protection Act (2018)
- Compliance with General Data Protection Regulation (GDPR)
- In order to be able to evidence compliance with regulatory requirements
- Compliance with the Data Security & Protection Toolkit
- Support effective decision making with regards to the deployment of resources

The key obligations upon staff to maintain accurate records relate to:

- Department of Health, Data Security and Protection Toolkit requirements
- Legal (Data Protection Act 2018)
- GDPR
- Care Records Guarantee
- Freedom of Information Act (2000)
- Environmental Information Regulations (2000)
- Access to Health Records Act (1990)
- Contractual (contracts of employment)
- Ethical (Professional codes of practice)
- Policy (Health Records Policy, Information Governance/Risk Policy)
- NHS Constitution

Please note this list is not exhaustive.

In addition staff are required to follow National guidance, and best practice associated with their specific profession as appropriate, for example the Nursing and Midwifery Council (NMC) Code.

The Trust is committed to ensuring and improving where possible the quality of data it uses for all purposes.

This policy is influenced by the Data Quality requirements set out in the Department of Health Data Security and Protection Toolkit.

It is prudent to note that the national payment system is the system under which the Trust receives the majority of its income under this system income is dependent on activity data concerning patient care. Inaccurate or late data could have a direct impact on the income received by the Trust.

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3 Definitions

3.1 Data

When using the word Data the Trust is referring to any information used to support the functions of the Trust, including information relating to patients, service users, employees, including bank agency, locum, or voluntary staff, and other business information.

3.2 Data Quality

Quality data is data which is fit for purpose for its intended uses, and complies with the Data Quality Standard set out in 3.6 below.

3.3 Information Assets

Information assets are defined by the Data Security and Protection Toolkit as operating systems, infrastructure, business applications, off-the-shelf products, services, user-developed applications, records (including paper records) and information. Therefore, when referring to information assets, the Trust is referring to any method of recording data, including paper, and electronic records.

3.4 Information Asset Owners (IAOs)

IAOs are senior individuals responsible for maintaining good Information Governance arrangements and standards within the relevant business / service areas of the Trust for which they have responsibility. The role of the IAOs is to:

- Ensure the Trust Information Asset Register remains up to date at all times.
- Understand and address the risks to the information assets they 'own'; and
- Provide assurance to the Senior Information Risk Owner (SIRO) on the security and use of these assets.
- Ensure the information assets they own comply with information governance requirements and that each information asset is supported by a System level Security Policy

3.5 Information Asset Administrators (IAAs)

The IAAs will provide support to their IAOs. To do this they will:

- Ensure that policies and procedures are followed;
- Recognise potential or actual security incidents and ensure they are reported;
- Consult their IAO on incident management;
- Ensure that the Trust information asset register is accurate, and kept up-to-date;
- Assist with IG Toolkit related work plans individual to specific areas.

3.6 Data Quality Standards

The Trust Data Quality Standards are set out below.

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3.6.1 Accurate and up to date:

All data must be correct and accurately reflect what actually happened. Therefore all reference tables including GPs and postcodes must be updated regularly and usually within a month of publication. Every opportunity must be taken to check a patient's demographic details with the patient themselves at every in-patient, out-patient and any associated service contact in accordance with service area specific Standard Operating Procedures (SOPs) as inaccurate demographics may result in important letters being mislaid, or the incorrect identification of patients. However, it is important to note that the accuracy and timeliness of data does not just relate to patients.

3.6.2 Valid:

Data should be within an agreed format which conforms to recognised national or local standards. Codes must map to national values and wherever possible, computer systems should be programmed to only accept valid entries. The Trust has adopted the use of the NHS Data Definition Dictionary to support staff in understanding the correct terminology and codes to use.

3.6.3 Complete:

Data should be captured in full. All mandatory data items within a data set should be completed and default codes will only be used where appropriate, not as a substitute for real data. The use of mandatory data items on the computer systems is to be encouraged but only where this would not cause undue delay. For key data items which are not mandatory on the computer system, it is vital that a list of records with missing items can be produced, to be actioned later.

3.6.4 Timely:

Data should be collected at the earliest opportunity; recording of timely data is beneficial to the treatment of the patient. All data will be recorded to a deadline which will ensure that it meets national reporting and extract deadlines. Standard operating procedures will consider organisational requirements and define timescales for each activity and in the absence of specific time requirements the default deadline will be 3 working days.

3.6.5 Defined and consistent:

The data being collected should be understood by the staff collecting it and data items should be internally consistent. Data definitions should be reflected in procedure documents.

3.6.6 Coverage:

Data will reflect the work of the Trust and not go unrecorded. Spot checks and comparison of data between months can highlight potential areas of data loss. Staff should be cognisant that if something is not recorded there is no auditable proof that something occurred, and as such could be challenged.

3.6.7 Free from duplication and fragmentation:

Patients should not have duplicated or confused patient records, and where possible data should be recorded once and staff should know exactly where to access the data. Where a

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duplicate record is created, for example in the event that a record is misplaced, records should be merged once the original is found.

3.6.8 Security and confidentiality:

Data must be stored securely and processed in line with relevant legislation and local policy in relation to confidentiality. All staff must pay due regard to where they record information, what they record, how they store it and how they share information ensuring they comply with national and local requirements, policies and procedures.

4 Scope

This policy applies to all staff working across the Trust, in whatever capacity, including agency, bank and volunteers, or sub-contractors. Failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement. Non-compliance may also lead to criminal action being taken.

This policy is intended to cover all types of data recorded digitally and on hard copy within the Trust, on all information assets, with particular emphasis on electronic patient administration, clinical information and electronic patient records systems and the data extracted from them for analysis for corporate management and reporting purposes. In order to ensure that Information assets are robust, reliable and comply with Information Governance requirements the Trust has in place an Information Asset Register, supported by a register of Information Asset Owners who are responsible and accountable for ensuring that systems under their control comply with relevant Information Governance requirements, and services are operating in line with relevant policies and procedures.

It is likely that the health record will increasingly be recorded using digital media, however it is important to note that patient information is still stored in paper records. This policy includes all paper health records within its scope and the various data quality standards and requirements apply equally to these records.

5 Purpose

The purpose of this policy is to set out what is required by all staff in order to ensure the quality of data used across the Trust.

Data Quality is essential for:-

- Efficient delivery of **patient care** e.g. by ensuring that patients are given appointments and admission dates based on clinical priority and length of waiting time.

- **Clinical governance** and minimising clinical risk e.g. wrong patient, wrong treatment.

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- **Trust Income under the NHS Payment System,** to ensure that the correct level of payment is secured from Commissioners and to monitor performance against Service Level Agreements. This is particularly important under the current payment system, where payment for spells varies according to Health Resource Groups (HRGs). HRGs are derived based on a number of factors including clinical coding, co-morbidities, demographics and length of stay.

- **Management information** is to enable decisions to be made on the basis of sound information, operational and strategic, local and national.

- **Performance measurement** against national trends and trends over time, so that we can continually plan improvements for our patients. Clinical and Performance Indicators are all largely based on HES (Hospital Episode Summary) data which is obtained from the CDS (Commissioning Data Set) which the Trust sends to SUS (the Secondary Uses Service).

- As a foundation on which **future investment** and **strategic decisions** will be based.

- To support **clinical audit** and **research and development**, with a view to improving patient care in the future

All staff needs to be able to rely on the accuracy of the information available to them, in order to provide timely and effective services regardless of whether they are patient facing or central support functions. To achieve this, all staff need to understand their responsibilities with regard to accurate recording of patient data, whether on a computer system or on paper, e.g. case notes.

6 Roles and Responsibilities

6.1 Chief Executive

The ultimate responsibility for use of information and its underlying data quality lies with the Chief Executive. The Chief Executive has delegated responsibility for ensuring that the Trust has in place a robust data quality framework, to ensure the quality of data recorded to the Senior Information Risk Owner.

6.2 Senior Information Risk Owner (SIRO)

The SIRO is Responsible for ensuring that an effective data quality assurance framework is in place across the Trust, and that all information risks have been identified, assessed, recorded, reported and are being mitigated effectively. This framework must include the following:-

- A robust, and embedded Data Quality Policy, supported by effective data validation procedures
- An effective Data Quality training programme
- An external and internal audit programme, relating to data quality audits.
- An up to date Information Asset Register supported by a register of Information Asset Owners and Information Asset Administrators.

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- A risk assessment programme in relation to information risks, including those relating to information assets and the associated assurance.
- A robust programme of work to improve data quality and address any issues identified.
- A relevant suite of Key Performance Indictors (KPI's) and benchmarking and associated reporting mechanisms to ensure that performance in relation to data quality is monitored and scrutinised as appropriate (as per Appendix C)

The SIRO is also responsible for ensuring that a robust Information Asset Owner (IAO) and Administrator (IAA) function is in place.

6.3 Caldicott Guardian

The Caldicott Guardian is responsible for reconciliation of Confidentiality and Data Quality agendas. The Caldicott Guardian is expected to make final recommendations on any instances where the requirements of good data quality are inconsistent with the need to protect confidentiality.

6.4 Executive Directors

Executive Directors are responsible for ensuring that data quality policies and procedures are in place and implemented across their areas of responsibility.

6.5 Information Steering Group (ISG - Data Quality)

The Information Steering Group will seek to:-

- Identify Data Quality Issues
- Investigate the cause of data quality issues (systems, processes, training, staff)
- Determine solutions to minimise or eradicate data quality issues
- Focus on data quality issues that have an impact upon:
    - The quality and safety of the care IW NHS Trust provides
    - Data recording that has an impact upon the income recovery and our commissioning relationships
    - National, regional and local data requirements and targets
    - Analysis that supports the clinical, operational, strategic and productive delivery of IW NHS Trust services

This group will report their findings and seek necessary approval for decisions to the Information Governance Subcommittee and provide assurance to the Performance Committee updating them of progress on data quality and providing assurance that data quality standards are being met or where this is not the case demonstrating that appropriate remedial action plans are in place.

The Information Steering Group has operational responsibility for data quality across the Trust, through monitoring compliance with data quality standards as set out in the Trust Data Quality Framework. They will also determine a number of Key Performance Indicators for data quality and monitor achievement of these performance measures on a quarterly basis as a minimum.

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The Information Steering Group, has responsibility to challenge and agree improvement plans developed following audits of compliance with data quality standards or other benchmarking information.

The implementation and maintenance of this policy will be managed on behalf of the Senior Information Risk Owner by the Information Steering Group.

The ISG will review performance against data quality KPI's.

6.6 Deputy Director of Information

The Deputy Director of Information is the designated lead for data quality in the Trust and is responsible for ensuring the operational delivery of the Trust Data Quality Framework, setting out key responsibilities and processes associated with ensuring data quality.

The Deputy Director of Information is responsible for the identification of data collection requirements arising from all initiatives (local and national, e.g. National Service Frameworks (NSFs), cancer information strategy) including the assessment of the feasibility of incorporating them into Electronic Patient Record systems, and the impact on overall data quality, and ensuring they are mobilised.

The Deputy Director of Information will ensure that as appropriate individual responsibilities are reflected in appraisal and performance reviews, and appropriately covered within job descriptions and inductions.

They will also ensure that team responsibilities are reflected in team meetings and performance reviews, and appropriately covered within departmental business plans, standard operating procedures, contingency plans and strategies.

Data Quality requirements must be considered at the outset, or design stage, of any review or implementation of projects, systems or policies to enable compliance with this policy.

6.7 Head of Performance Information and Decision Support

The Head of Performance Information and Decision Support is responsible for:

- The quality of processing of data between primary sources and the Trust's data warehouse / reporting systems
- The quality of reports produced from the data warehouse / reporting systems
- The production of data quality reports and key performance indicators from the data warehouse / reporting systems.

6.8 Information Systems Team

For those systems, or information assets owned by the Deputy Director for Information Communication Technology, the Information Systems Team is responsible for:

- Undertaking information risk assessments and providing assurance to the SIRO in relation to information assets for which they have responsibility.

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- Ensuring information systems are fit for purpose and comply with best practice in relation to Data Quality and Governance.
- Provision of data quality monitoring reports
- Development and delivery of training in relation to the use of information assets.

The Information Systems Team is also responsible for collation and communication of all Information Standards Notices (ISNs) and data standards requirements.

6.9 Information Asset Owners and Department Managers

Information Asset Owners and Department Managers are responsible for ensuring that staff attend training in the use and applications of information assets, that up to date standard operating procedures for data collection, and recording are maintained for each operational area, and are being followed and that staff understand their responsibilities in relation to data quality. The SOP should also include appropriate business continuity arrangements to ensure data quality is maintained in the event that the information asset is unavailable.

Information Asset Owners and Department Managers are responsible for building data quality responsibilities of their staff into existing management procedures, including:

- Job Descriptions and Person Specifications
- Induction
- Appraisals and Performance Reviews
- Relevant mandatory training compliance e.g. Information Governance Training

Information Asset Owners and Department Managers are responsible for acting on feedback about the quality of data in their area, including regular review of data quality monitoring reports to identify data quality issues within their department and development of local data quality key performance indicators.

Information Asset Owners in particular are responsible for ensuring that information assets used are safe, efficient and effective and being utilised in the correct manner, and providing assurance to the SIRO regarding this. This will include the identification and mitigation of relevant information risks (for further information please see the Information Governance Policy including Information Risk Management)

Information Asset Owners must ensure that all information assets are supported by policies or Standard Operating Procedures (SOP) which set out how the information asset should be used. These SOP's must be appropriately ratified and be easily available to staff.

Information Asset Owners and Department Managers will ensure that as appropriate individual responsibilities are reflected in appraisal and performance reviews, and appropriately covered within job descriptions and inductions.

They will also ensure that team responsibilities are reflected in team meetings and performance reviews, and appropriately covered within departmental business plans, standard operating procedures, contingency plans and strategies.

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6.10 Information Asset Administrators

Information Asset Administrators are required to support the IAO's in discharging their duties effectively.

6.11 All staff

The fundamental principle of data quality is that data should be right first time, which means that the responsibility is held at the point at which it is collected and recorded, whether the person recording the information is clinical, technical or clerical.

Therefore all staff are responsible and accountable for the quality of data they collate and record.

Staff must ensure that they comply with the requirements of this and other policies and procedures relating to their role.

7 Policy detail/Course of Action

7.1 Recording Data

As indicated above, the Trust has adopted 8 data quality standards that staff must adhere to at all times, when recording data:-

Accurate and up to date, in that the data recorded must be a true reflection of what has occurred whether that be a record of a conversation or activity, for example medication that was prescribed or administered.

Valid, similarly to the data being accurate, the date recorded should be well-founded and credible. Therefore where data has been provided by a third party, where possible it must be stated who shared the data (bearing in mind the need to safeguard the third party) as this may impact on its credibility.

Complete, it is important when recording any data that all the relevant information is contained, bearing in mind that what may seem like an unnecessary, or trivial fact may turn out at a later stage to be a crucial part in a jigsaw.

Timely, it is vitally important that data is captured and recorded without delay, as delays in recording may result in patients receiving inappropriate treatment, or important treatment failing to be given. Similarly delays in recording information may result in the Trust failing to be able to demonstrate the achievement of performance measure.

Defined and consistent, it is important the staff record information in a standardised way, as the data they are recording may need to be used by another colleague, and if they are unable to interpret the data accurately this may result in steps being taken that are inappropriate. Therefore staff are asked not to use abbreviations unless they are universally utilised as abbreviations may have different meanings in different services or across different providers. This is particularly pertinent to staff operating within different disciplines.

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Coverage, similarly with data being complete, it is imperative that data covers the breadth of the intervention or activity. Therefore where a clinician attends to a patient to undertake a particular activity, for example dressing a wound, but also undertakes a wider pressure damage risk assessment, both elements must be recorded, as this provides an auditable evidence trail, and defensibility for staff.

Free from duplication and fragmentation, it is important that records themselves are not duplicated, as this can result in key information being missed if the practitioner is utilising just one of the records, therefore staff must make every effort to ensure the safe keeping of records and that duplicate records are not created. However, it is also important that information within records is not duplicated as this can make it difficult for practitioners to find information.

Security and confidentiality, staff must make every effort to ensure the security and confidentiality of data, by using the relevant information assets available to them in the way prescribed by the Trust set out in the various policies and procedures. Where staff are unsure they must seek the advice of their line manager. They must pay due regard to who is within hearing distance when discussing any confidential data, and must understand and adhere to relevant confidentiality policies and procedures.

7.2 Auditing Data Quality

The Deputy Director of Information is responsible for coordinating and overseeing the Trusts annual data quality audit programme, both in terms of audits undertaken on behalf of the Trust by our internal auditors and in terms of other audits undertaken by Trust staff. An audit should be undertaken by our internal auditors at least biennially. Trust staff will undertake data quality audits on a biannual basis as a minimum

Scoping of the data quality audits will be undertaken by the Information Steering Group, who will identify the services to be audited and the requirements for validation. All audits will result in a finding and recommendations report including where appropriate an action plan.

The Systems Management Team is required to run regular validation routines in order to continually monitor data quality as part of other procedures. These routines are to check for data completeness and data validity against key mandatory data items such as NHS Number, DoB etc. These routines are continuously run when a new Commissioning Data Set (CDS) file is generated.

In addition, Information Analysts in PIDS will highlight significant variations in activity levels and undertake investigate to ensure that the variations are real rather than the result of data recording or gaps. Initially queries will be raised with service leads and corrections made where necessary. Where queries remain outstanding these will be escalated through the contracting team and the SLA Management process.

External data quality monitoring and reporting for example as a consequence of reporting to the Secondary Users Service (SUS), the Mental Health Minimum Data Set (MHMDS), the Community Services Data Set (CSDS) and the Data Protection Security Toolkit data quality compliance will be used to identify and correct data quality issues.

Wherever a national target does not apply or is not considered sufficiently challenging, external and internal benchmarking will be utilised to monitor trends and review target levels for KPIs.

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Apart from internal measures, there are various tools available to enable the Trust to assess its performance regarding data quality:

- HES Data Quality Indicators
- SUS Data Quality reports
- National Data Quality Maturity Index
- Data quality reports taken from SUS data
- Coverage reports regarding presence of patient's NHS numbers on PAS
- Complaints & Queries
- Internal and external audit reports on data quality.
- Information Governance Toolkit
- Health Records accreditation
- Annual Record Keeping audits, monitored by the Trust Clinical Effectiveness Lead

The Deputy Director of Information will ensure that these tools are utilised as appropriate across the Trust.

NB this list is not exhaustive and other internal mechanisms to assess and improve data quality will be utilised as appropriate.

7.3 Monitoring of Data Quality (reporting mechanisms)

The results from all data quality audits will be reviewed by the Information Steering Group, including the findings and recommendations reports and resultant actions plans. The Information Steering Group will take responsibility to challenge and agree action plans to ensure they are fit for purpose. In addition they will continue to monitor progress against the action plans until all actions are completed and coordinate re-audits to assess the effectiveness of the actions undertaken.

The Information Steering Group, will also determine annual Key Performance Indicators relating to data quality and will review progress against these measures on a quarterly basis as a minimum, ensuring and risks are identified, recorded and reported in line with the Trusts Risk Management Strategy and Policy.

The Information Steering Group will escalate matters of concern or where decisions are required to be made in line with the Trusts Standing Financial Instructions to the Trust Performance Committee, who in turn will exception report to the Trust Leadership Committee.

The Information Steering Group will provide assurance to the Information Governance Sub Committee, in relation to data quality matters.

Exception reporting in relation to data quality to the Trust Board will be as part of the Trust Board Performance Report.

Where trends in data quality are identified these will be reported back to the relevant staff member, service manager, Clinical Director, Information Asset Owner as appropriate to ensure that actions can be taken to improve systems and processes.

Where data quality issues are identified and further actions, including training are identified, appropriate feedback to the relevant member of staff will be provided by the Information

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Systems Team. Where issues persist, and capability issues are identified the member of staff's access to systems will be removed. It will then be the responsibility of their manager to determine the impact that this has on the staff members ability to carry out their duties and therefore steps to be taken, for example capability.

7.4 How Data Quality can be improved

The Trust recognises that two key elements to improving data quality are good training and robust and effective procedures.

The Trust acknowledges that good quality data can be achieved by careful monitoring and error correction but it is more effective and efficient for data to be entered correctly first time. In order to achieve this, appropriate system configuration is essential and good procedures must exist so that staff can be trained and supported in their work.

Information Asset Owners are responsible for ensuring that there are specific policies or procedures in place in relation to all information assets under their control, which set out as a minimum, when the information asset should be used, how it should be used and by whom and how the quality of data recorded will be monitored.

Where appropriate, Information Asset Owners must ensure that training is available for staff to use the asset, and that information risks associated with each asset are actively identified, and being mitigated, ensuring that they provide assurance to the SIRO.

The data quality elements of any procedure must be defined in such a way so as to be unambiguous to those who are expected to carry out the tasks. They should reflect national and local standards. The Trust has standard templates which can be used for creating Standard Operating Procedures (SOPs).

At least every three years or in response to changes in legislation, best practice etc., procedures need to be reviewed to take account of any changes in national standards and definitions, including national payment system definitions. Tight version control is essential so that staff in all parts of the Trust are using the same procedures which reflect current data definitions. Therefore all staff producing documents of this nature must follow the Trust Document Control Policy.

Department Managers working alongside the Information Asset Owners must ensure that job Descriptions reflect specific and general responsibilities for encouraging good quality data.

7.5 Responding to identified data quality issues (errors or omissions)

It is acknowledged that on occasions, data quality issues such as errors or omissions will be identified. It is imperative that where this is the case they are reported to the relevant Information Asset Owner, who will be responsible for identifying trends in data quality issues and taking steps to amend processes to reduce any margin for error.

In addition where examples of poor data quality are uncovered, the audit trail should be used to identify the member of staff responsible for the error or omission. The identified person should then be asked to make any corrective entry, or at least be informed of the error, so that they can be made aware of the implications of their action and the importance of data items. Under

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normal circumstances it will be the line manager who shares this information with the staff member in question.

Where there is a pattern of such errors or omissions with particular staff, the potential consequences must be considered and due regard paid to patient safety. Managers must follow appropriate processes to protect patients, and ensure data quality including capability or disciplinary procedures as appropriate.

Errors must be amended as soon as possible after they have been identified in line with national and local policies, procedures and SOPs relating to correction of records.

Where users are unable to correct their own errors, due to the policy of the Trust for the use of the PAS, records of the users errors will be kept for feedback and retraining as necessary.

8 Consultation

The Information Steering Group was consulted in the preparation of this Policy.

9 Training

All users of computer systems will be trained, and will not be issued with passwords until they are trained. Access to patient administration and clinical information systems must be appropriate, according to job role, and must be authorised by the line manager, and only once the individual in question has undertaken Information Governance training relevant to their role. Indeed annual IG training is a mandatory requirement for all Trust staff.

On issue of passwords, users must sign an undertaking to take reasonable steps to ensure the accuracy of information that they enter on the computer system.

10 Monitoring Compliance and Effectiveness

The Trust will, as a matter of routine, monitor performance in collecting and processing data according to nationally and locally defined standards, and provide appropriate feedback to all staff. This activity will be coordinated by the Deputy Director of Information, and reported through the Information Steering Group.

The Information Steering Group will provide regular reports on indicators of performance for senior operational managers to review and develop targeted improvement plans. These reports will be further utilised as part of Divisions Performance Reviews.

Where outcomes are unsatisfactory, root causes will be reviewed and performance management measures implemented at Division, team or individual level, as required to deliver a level of performance which supports the Trust’s duty of care to service users, as well as statutory performance and financial targets.

Action plans for all areas identified as a concern will be developed and delivery will be overseen by the Information Steering Group.

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11 Links to other Organisational Documents

Information Governance and Risk Policy
Information Security Management - Code of Practice
Confidentiality: NHS Code of Practice
Health Records Policy

12 References

Data Protection Act (1998)
Department of Health Information Governance Toolkit
Public Records Act (1958)

13 Appendices

Appendix A – Financial and Resourcing Impact Assessment on Policy Implementation
Appendix B – Equality Impact Assessment
Appendix C – Data Quality Assessment

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Appendix A

Financial and Resourcing Impact Assessment on Policy Implementation

Document title	Data Quality Policy

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs (no change due to this policy)			
Training Staff (no change due to this policy)			
Equipment & Provision of resources (no change due to this policy)			

Summary of Impact: There will be a manpower impact of this policy; however this is necessary in order to safely deliver the services of the Trust. The Trust employs a number of staff who within their primary role have responsibility for maintenance of an effective risk management system. In addition staff across the Trust will have specific responsibilities; however this will fluctuate depending on the number and nature of risks.

Risk Management Issues: This policy is document is designed to support effective risk management across the Trust.

Benefits / Savings to the organisation: Effective risk management will support the Trust to deliver its service efficiently, effectively with due regard to the financial envelope and quality agenda.

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If "YES" please specify:

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:		

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Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc.		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

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Appendix B

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Data Quality Policy
Purpose of document	Set out what is expected from Trust staff in order to ensure quality data
Target Audience	*All staff*
Person or Committee undertaken the Equality Impact Assessment	*Iain Hendey*

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	**Negative Impact**	**Reasons**
Gender	Men	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Women	*N/A*	*N/A*	*Policy relates to how records are maintained*
Race	Asian or Asian British People	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Black or Black British People	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Chinese people	*N/A*	*N/A*	*Policy relates to how records are maintained*

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	People of Mixed Race	*N/A*	*N/A*	*Policy relates to how records are maintained*
	White people (including Irish people)	*N/A*	*N/A*	*Policy relates to how records are maintained*
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	*N/A*	*N/A*	*Policy relates to how records are maintained*
Sexual Orientation	Transgender	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Lesbian, Gay men and bisexual	*N/A*	*N/A*	*Policy relates to how records are maintained*
Age	Children	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Older People (60+)	*N/A*	*N/A*	*Policy relates to how records are maintained*
	Younger People (17 to 25 yrs.)	*N/A*	*N/A*	*Policy relates to how records are maintained*
Faith Group			*N/A*	*Policy relates to how records are maintained*
Pregnancy & Maternity			*N/A*	*Policy relates to how records are maintained*
Equal Opportunities and/or improved relations			*N/A*	*Policy relates to how records are maintained*

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

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3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	04-09-2019

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Appendix C

1. **Data Quality Assessment: General**

Issue	KPI	Action	Responsibility	By When	Monitoring mechanism	Impact
Timeliness of data entry	All data to be completed within 48 hours and no longer than 5 days after the event.	Timely recording of data and monitoring and performance management of late entry.	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Late data entry report.	Clinical information availability, timely data for operational and contract monitoring. Confidence in IWNHST data.
All activity recorded	All clinically relevant activity entered onto our clinical and administrative systems in accordance with procedure.	Completeness of recording and monitoring	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Expected activity levels used to indicate potential under recording. Regular Consultant sampling of coded activity.	Clinical information availability, timely data for operational and contract monitoring. Confidence in IWNHST data.
Incorrect dates recorded, incompatible with patient pathway	All Dates recorded correctly such as referral date before 1st contact date, etc.	Correct data entry and correction of data errors	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Series of logical rules regarding dates to be developed and monitored.	Correct clinical and administrative recording and performance on 18 weeks

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NHS number completeness	99% of patients have their NHS Number recorded and it is used as the primary identifier for communication about the patient	Patient registration via the spine through thorough searches for the correct patient. NHS number communicated between services	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Missing NHS Number report by service area	Identification uniquely of the correct patient resulting in safe clinical care and communication internally and with partners. Results additionally in correct demographics (e.g. postcode, GP and commissioner codes)
Registration of duplicate patients / multiple records	Zero duplicate patient records to result in a single record per patient	Full and effective search for existing patient records. Where duplicates have occurred patient record merger.	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Duplicate patients report	Complete patient clinical record between services and over time helping ensure safer services.
Ethnicity recorded	99% of patients have a valid Ethnicity code recorded.	Request ethnicity at registration or when not present for existing patients	Head of Ops, Service Leads, General Managers, Line managers, each staff member, IM & PIDS	Ongoing	Missing ethnicity report by service area.	Ethnicity known for conditions where ethnicity is valid, meet legal equality and diversity requirements to monitor equitable provision
Outstanding Discharge Summary	100% of patients discharged from hospital	Ensure timely completion of discharge	Clinical teams	Ongoing	Outstanding discharge summary report	Improved timeliness of information

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completed on ISIS	admission should have discharge summary completed on ISIS within 2 days of discharge	summaries in ISIS				relating to patients to GPs. Improved coding process and reporting important for PbR.

Referral to Treatment (RTT)

Issue	Requirement	Action	Responsibility	By When	Monitoring mechanism	Impact
PAS Waiting list entries with missing intended management i.e. Day case / Inpatient	100% of waiting list entries to have valid intended management entry	Ensure intended management is available on DTA form and recorded in PAS.	Clinicians, PAAU staff, General Managers	Ongoing	RTT Qlikview Application	Ensure appropriate planning and scheduling of patients and accurate reporting
PAS Waiting list entries with missing Anaesthetic Type i.e. LA / GA / SED	100% of waiting list entries to have valid Anaesthetic Type entry	Ensure anaesthetic type is available on DTA form and recorded in PAS.	Clinicians, PAAU staff, General Managers	Ongoing	RTT Qlikview Application	Ensure appropriate planning and scheduling of patients and accurate reporting
PAS Waiting list entries with missing Procedure Length of Time	100% of waiting list entries to have valid Procedure Length of Time recorded	Ensure estimated procedure length of time is available on DTA form and recorded in PAS.	Clinicians, PAAU staff, General Managers	Ongoing	RTT Qlikview Application	Ensure appropriate planning and scheduling of patients and accurate reporting

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Patients added to the inpatient waiting list and their RTT clock inappropriately re-set to zero weeks	The proportion of patients who have a DTA Date equal to RTT start date should not exceed 60%	Ensure appropriate RTT Pathway management in PAS. Validation of records with same DTA and RTT start date.	Clinicians, PAAU staff, OPARU, General Managers, Information Management, PIDS	Ongoing	RTT Qlikview Application	Ensure appropriate management of RTT pathway and accurate reporting
Patients on the active PTL with a TCI date in the past.	Zero patients with a TCI date < PTL refresh date.	Ensure all TCI Dates are removed or updated if patient pathway is amended.	PAAU, General Managers.	Ongoing	RTT Qlikview Application	Ensure appropriate management of RTT pathway and accurate reporting
Patients on the inpatient waiting list with no active RTT pathway.	Zero patients with no active RTT Pathway.	Ensure appropriate RTT Pathway management in PAS.	OPARU, PAAU, Outpatient Team Leaders, General Managers.	Ongoing	RTT Qlikview Application	Ensure appropriate management of RTT pathway and accurate reporting
Patients on consultant led episode with a GP referral with no active RTT pathway.	Zero patients with no active RTT Pathway.	Ensure appropriate RTT Pathway management in PAS.	OPARU, PAAU, Outpatient Team Leaders, General Managers.	Ongoing	RTT Qlikview Application	Ensure appropriate management of RTT pathway and accurate reporting
Patient pathways with obsolete RTT codes recorded	Zero RTT pathways with obsolete RTT codes	Ensure appropriate RTT Pathway management in PAS.	OPARU, PAAU, Outpatient Team Leaders, General Managers.	Ongoing	RTT Qlikview Application	Ensure appropriate management of RTT pathway and accurate reporting

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A&E

Issue	Requirement	Action	Responsibility	By When	Monitoring mechanism	Impact
The number of 4 hour breaches in Symphony not matching daily spreadsheet	Symphony breaches to match daily spreadsheet	Ensure timely update of Symphony.	A&E Staff, PIDS	Ongoing	A&E Qlikview Application	Enable use of symphony for all A&E reporting avoiding duplication.
Patients in A&E with no end date or time	Zero patients in A&E with no end date & time more than 24 hours after start date	Ensure timely update of Symphony.	A&E Staff, PIDS	Ongoing	A&E Qlikview Application	Enable use of symphony for all A&E reporting avoiding duplication.
Patients breaching 4 hour standard with no breach reason recorded	Zero patients breaching the 4 hour standard with no breach reason recorded	Ensure timely update of Symphony.	A&E Staff, PIDS	Ongoing	A&E Qlikview Application	Enable use of symphony for all A&E reporting avoiding duplication.
Patients with a stage of pathway start time but no end time i.e. patient sent for Imaging.	Zero patients with a stage of treatment start time but no end time.	Ensure timely update of Symphony.	A&E Staff, PIDS	Ongoing	A&E Qlikview Application	Enable use of symphony for all A&E reporting avoiding duplication.

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Community

Issue	Requirement	Action	Responsibility	By When	Monitoring mechanism	Impact
Missing attendance status on Service Group Diary module of PAS	100% of activity should have a valid attendance status recorded in PAS	Ensure attendance status is recorded appropriately in PAS	All staff recording activity in clinicians diary module	Ongoing	Community Dashboard	Correct activity levels are recorded reported and charged for.
Community Nursing / Community Matron Contacts – Missing Priority Code - information required for CSDS and Monitor GRR	100% of contacts should have a valid Priority Code Recorded.	Ensure Priority Code is recorded	Community Nursing / Community Matron Teams	Ongoing	Community Dashboard	Completeness of recording in CSDS, improved score on GRR
Community Nursing / Community Matron Contacts – Missing Primary Reason for Referral - information required for CSDS and Monitor GRR	100% of contacts should have a valid Primary Reason for Referral Recorded.	Ensure Primary Reason for Referral is recorded	Community Nursing / Community Matron Teams	Ongoing	Community Dashboard	Completeness of recording in CSDS, improved score on GRR
Community Nursing / Community Matron Contacts – Missing Referral Closure Date - information required for CSDS and Monitor GRR	100% of contacts should have a valid Referral Closure Date Recorded.	Ensure Referral Closure Date is recorded	Community Nursing / Community Matron Teams	Ongoing	Community Dashboard	Completeness of recording in CSDS, improved score on GRR

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Mental Health

Issue	Requirement	Action	Responsibility	By When	Monitoring mechanism	Impact
Patients in PARIS not allocated to a HONOS cluster	90% of MH patients should have a valid Cluster allocated and recorded in PARIS	Ensure cluster is recorded appropriately in PARIS	All staff recording MH activity in PARIS	Ongoing	PARIS Reports	Appropriate clusters recorded for patient case management and reporting and shadow PbR.
The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items.	Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI)	Ensure PARIS Configuration complies with MHSDS and services are recording information appropriately.	Information Systems and all staff recording MH activity in PARIS	Q2 2019/20	National reports	Links to CQUIN Payment and mandatory compliance of MHSDS.

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