

Data Quality Policy

Department / Service:	Information Department
Originator:	Information Governance Manager
Accountable Director:	Director of Finance/SIRO
Approved by:	Information Governance Steering Group
Date of Approval:	15 th January 2018
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This is the most current document and should be used until a revised version is in place	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All

Policy Overview:

The Trust is aware of the necessity to ensure high levels of Data Quality exist in all forms of personal confidential data (PCD) it records, and information it produces, to comply with its legislative obligations, to facilitate the provision of the highest standards of patient care and ensure corporate records are accurate.

Pursuant with the aim of achieving a culture of unconscious competence within its workforce in relation to Data Quality, this policy outlines the roles and responsibilities of all staff.

The Trust will aim to achieve and maintain the highest standards contained within the Information Governance Toolkit.

Key amendments to this Document:

Date	Amendment	By:
Jan 2015	Includes latest guidance and reflects organisational changes and the audit cycle.	IG Manager
Feb 2017	Document extended for 6 months while recruiting to post of Data Quality Manager	IG Manager
Aug 2017	Document extended for 6 months as per TMC paper	TMC
Dec 2017	Document extended for 3 months as per TLG recommendation	TLG
Jan 2018	Document reviewed and revised to reflect the latest Trust policies and NHS Standards.	Information Manager
January 2020	Document extended for 3 months whilst undergoing approval process	Information Manager

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Right First Time Reference Guide

1. Introduction

The Trust recognises the necessity for the recording of accurate, relevant, timely, reliable, valid and complete patient information to support;

- The provision of high quality and safe patient care
- The delivery of its core business objectives
- The monitoring of activity and performance for internal and external management purposes.

It is the responsibility of ALL staff, clinical and non-clinical, to ensure that all information which is recorded, both in paper format and on electronic systems, conforms to the highest levels of data quality.

In order to achieve this staff must ensure that data conforms to both nationally and locally defined standards, by following the guidelines and procedures provided for data collection and reporting.

The requirement for high level data quality is outlined in the following legislative and national guidance (the list is not exhaustive);

- The Data Protection Act 1998, in particular principle 4 which states “Personal data shall be accurate and, where necessary, kept up to date.”¹
- Section 92 of the Care Act 2014 which creates an offence of supplying, publishing or otherwise making available information, which is false or misleading in a material respect.
- CQC Regulations;
 - Regulation 12: Safe Care and Treatment, specifically the component 12(2)(c) which states that the Trust must be "ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;"
 - Regulation 17: Good Governance, specifically the component 17(2)(c), which states that the Trust must "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;"
 - Regulation 17: Good Governance, specifically the component 17(2)(d) which states the Trust must "maintain securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity;"
- The Francis Report (21013) into standards of care provided by Mid Staffordshire Foundation Trust, Rec No 269 states “The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.”
- NHS Data Dictionary, which gives common definitions and guidance to support the sharing and comparison of information across the NHS.
- The Information Governance Toolkit, which is a Department of Health mandated set of standards, including Data Quality requirements, which the Trust must evidence they are compliant with.

The Data Quality policy outlines the Trust processes to ensure compliance with these requirements.

¹ From 25 May 2018 the Data Protection Act will be replaced by the General Data Protection Regulation/UK Data Protection Bill.

2. Scope of this document

The scope of this Policy is Trust Wide, with both clinical and non clinical staff responsible for the accuracy and completeness of any personal confidential data (PCD) they record.

The principles outlined in this policy are applicable to ALL data recorded by, and information produced by the Trust, in either paper or electronic format, including, but not limited to, the following;

- OASIS
- Patient First
- CRIS
- ICE
- ESR
- WinPath
- Ascribe
- Bluespier
- DATIX
- OLM
- Mortality Review Database
- Mandatory Data Returns
- K2
- Medicode

Each department must produce their own procedures to provide their staff with detailed guidance regarding data collection, recording and validation, in line with this policy.

The Data Quality Policy is to be read in conjunction with;

- The Corporate Records Management Policy and Procedure (WAHT-CG-127)
- The Clinical Coding and Auditing Policy and Process (WAHT-CG-774)
- The Information Governance Policy (WAHT-CG-579)
- The Data Quality Framework

3. Definitions

- **Data** – that which is input to a system, or extracted from a system in an unanalysed format.
- **Information** – that which is produced by extracting and analysing data from a system(s)
- **Data Quality** – the extent to which the data conforms to the dimensions of data quality.
- **Dimension** – a facet of data that can be measured or assessed against defined standards in order to determine the quality of data. For the purpose of this policy the dimensions are Accurate, Valid, Reliable, Timely, Relevant and Complete.
- **Accurate (dimension)** – the level to which the data corresponds to real world values at the point in time it is being used.
- **Valid (dimension)** – the level to which the data conforms to its associated rules and definitions.
- **Reliable (dimension)** – the level to which the data is consistent across time and systems.
- **Timely (dimension)** – the level to which the data is available when it is expected and needed.
- **Relevant (dimension)** – the level to which the data answers the purpose for which it is collected.
- **Complete (dimension)** – the level to which a data item or data set is complete.

4. Roles and Responsibilities

- **Trust Board** - Has overall responsibility for ensuring this policy is implemented.
- **Trust Leadership Group (TLG)** - Receives and reviews status reports from the Information Governance Steering Group. Oversees and authorises changes in Trust Policy and Procedures which are required to mitigate any Data Quality issues and associated risks. Reports to the Trust Board.
- **The Information Governance Steering Group (IGSG)** - Receives and reviews reports from the Data Quality Steering Group, including status reports and requests for changes in Trust Policy and Procedures to improve data quality. Reports to the TLG.
- **The Data Quality Steering Group (DQSG)** - Investigates any activity related to Data Quality. It is authorised to seek any information it requires from any employees, and all employees are directed to co-operate with any reasonable request made by the Data Quality Steering Group. Reports to the IGSG. Activities include;
 - Ensuring Policy and Procedure Documents surrounding data collection, processing and validation are in place, up-to-date and conform to National Standards.
 - Ensuring the recommendations from any data quality related Serious Incidents are implemented.
 - Ensuring all staff are receiving appropriate training, are adhering to trust policies and procedures regarding data collection and have an understanding of the importance of the data they are responsible for entering onto the system.
 - To communicate any changes in practice, standards and any national changes in data / information collection.
 - To commission audits / monitoring of information processes and feedback results / recommendations through the team and onto the Information Governance Steering Group.
 - To work with the Clinical Application Team to improve the set up / functionality of patient systems, in order to reduce the possibility of entering data incorrectly.
 - To review and prioritise proposed enhancements to the PAS system.
 - To liaise with other trust working groups and committees in order to promote data quality issues.
 - Encourage clinical involvement in the provision and use of Trust data.
 - To use all available forums as a means of communicating trust-wide data quality issues.
- **The Caldicott Guardian** - Ensures that Patient Identifiable Data (PID) is handled, accessed and distributed according to National and Trust protocols and legislation.
- **The Clinical Lead for Data Quality** – Leads on ensuring clinical engagement with the data quality agenda.

- **The Assistant Director of Information and Performance** - Responsible for ensuring the Information Department, which includes the Data Quality Team, are monitoring and managing the data quality agenda according to national and local policies and procedures.
- **The Information Department - Data Quality Team**
 - **Data Quality Manager** - Leads in communicating the Data Quality Agenda Trust Wide. This includes communicating any national data quality policy changes, new Information Standard Notices (ISN), providing guidance on data quality issues, and leading on data quality investigations into identified issues. Reports the results of any investigations to the DQSG
 - **Data Audit Clerk** – Information Governance Standard 506 is a requirement for all trusts to have a documented procedure and a regular audit cycle for accuracy checks on service user data. The results of these audits should be reported to the DQSG and the IGSG.
 - **Data Quality Clerks** - Data quality reports provided by the information department are updated daily and patients found with missing patient data are updated using the national databases before matching and updating patient information locally.

- **The Information Department - Information Governance Team**

Ensures Trust data is held securely and confidentially, obtained fairly and efficiently, recorded accurately and reliably, used effectively and ethically and shared appropriately and lawfully.

- **The Information Department - Analysts and Performance Team**

This team is responsible for the production of regular reports to trust management boards, committees and groups, the completion of statutory external returns and data submission and the production of both ad-hoc and routine reports developed to support clinical directorate management and decision making.

Data used in the production of these reports is extracted from patient systems and the information staff take responsibility for the validation (identifying and reporting the errors) once extracted. Any areas of concern identified by the team are escalated to the Data Quality Team.

- **The Information Department - All**

All members of the Information Department handle data on a daily basis, and are responsible for handling and processing the data according to the Caldicott Principals.

- **Information Asset Owners** - Staff who have responsibility for managing local electronic systems for record keeping. They must ensure that all systems for which they are responsible comply with the NHS Data Dictionary and Information Governance protocols. Due to the lack of interoperability between some legacy systems, procedures should also be in place for updating demographic data from local systems to OASIS.

- **Divisional/Directorate Management Teams** - Have responsibility for ensuring that data quality is regarded as a key issue within their teams, that suitable representation is made on the DQSG aimed at the implementation of this policy and that those responsible for the dissemination of policies, training and the investigation of issues are provided with the required access to users. Additionally Directorates must ensure that case notes are available to the coding teams the day after discharge for completion of the coding process.
- **Clinical Coding** – Have the primary responsibility for ensuring all inpatient episodes are fully and correctly assigned with appropriate diagnosis and procedure codes (ICD10 & OPCS coding rules and conventions), to meet the trust deadline in regard to timeliness. Included in the coding process is the validation of admission data in relation to consultant, specialty, admission, transfer and discharge dates. One off errors are escalated to the Data Quality Team for correction. Any patterns of recurrent bad practice are reported to the Coding Manager, and escalated to the DQSG for further investigation where appropriate. The Coding Manager will take responsibility for conducting clinical coding audits in order to monitor and review practice and will liaise directly with medical staff regarding the continued improvement of the quality of source documentation used in the coding process.
- **Clinicians** – Are responsible for completing the trust source documentation for coding. The source documentation should be completed according to the guidelines contained with the Coding Booklet, available on the intranet, or from the Coding Team.
- **The Clinical Applications Support Team** – Members of the Acute ICT service that provides support for the trusts Patient Administration System (OASIS) and other systems including A&E (Patient First), and to their Users. They provide advice on system usage and liaise with the system suppliers to resolve errors and to clarify the effects of changes in system usage.
- **Information Technology Trainers** - Members of the Acute ICT services provided by the Trust. The IT Trainers are responsible for delivering system training which includes materials to support the recording of accurate and timely data in all systems. Access to systems will not be granted until satisfactory completion of training. Where other departments deliver training, this will be with the agreement of the Training Department, who will be responsible for ensuring it is to the required standard.
- **All System Users** - All users of systems employed for the collection of any personal confidential data (PCD) have responsibility for ensuring that the data they collect and record is timely, accurate and consistent and that Trust policies and procedures relating to this data are adhered to.

5. Key System: The Patient Administration System (OASIS)

PAS is the corporate system for the trust and has a number of modules that cover the wide range of administrative processes which include, the patient master index, inpatients, outpatients and waiting list data. Data Quality errors on OASIS could mean missed or delayed appointments, correspondence being misdirected and when admissions, discharges and transfers are not entered in a timely fashion patient flow within the Trust is hindered.

In addition, data is extracted from OASIS and submitted to SUS (Secondary Uses Service) to facilitate payment to the Trust.

Therefore it is essential that all patient related activity is recorded in an accurate and timely manner and according to national data standards.

The system administrator is responsible for high level system documentation and procedures:

It is the responsibility of divisions/departments to ensure that procedures are in place to cover the following areas of data input:

Master Patient Index

- Registering a patient
- Making changes to a patient registration
- Recording deaths
- Ensuring patient alerts are recorded and reviewed appropriately.

Outpatients

- Recording of a referral
- Use of the waiting list module (including booking)
- Making an appointment
- Recording attendance, or otherwise, and outcomes

Inpatient and Day Case Waiting Lists

- Adding patients to the lists
- Managing the lists and recording periods of suspension
- Offering dates of admission and recording attendance, removal or otherwise

Admitted Patient Care

- Recording an admission
- Entering any ward or consultant transfers or periods of home leave
- Recording discharges

Case note Tracking

- Recording the location and movement of health care records

The Patient Administration System must be regarded as the principal source of patient information and where departmental systems are in place, care must be taken to ensure that any updates in demographic data recorded on the departmental system are also entered on the Patient Administration System.

Other systems which require procedures are in place to cover areas of data input include;

Accident and Emergency

- Recording arrival of patient in department
- Noting patient's progress through department
- Clinical coding
- Recording outcome of attendance

Clinical Correspondence

- Preparing and editing clinical correspondence
- Marking correspondence complete

Maternity Module

- Registering community midwifery booking details
- Entering labour and delivery details
- Recording postnatal discharge

6. Information Governance Toolkit

The Department of Health requires organisations to be assessed against Information Governance policies and standards by entering evidence of compliance via the online Information Governance Toolkit (IGT).

The Data Quality Manager, in conjunction with the members of the Data Quality Steering Group, will be responsible for on-going monitoring, and production of evidence for the IGT for the data quality related standards.

7. The NHS Number

The NHS Number is the preferred identifier when transferring data across NHS organisations. All clinical documentation, both paper and electronic, must include the NHS number when it is known. It is mandatory for inclusion in all admitted patient care commissioning dataset transmissions and when present other patient identifiers are removed. For clinical documentation it is used as a check on patient identification.

Every effort will be made via use of the NHS Summary Care Record to improve and maintain the completeness, accuracy and verification of this identifier both by individual enquiries and by a programme of batch tracing.

8. SUS (Secondary Uses Service)

Data collected within the Trust is submitted to SUS. Quality checks on this data are performed prior to the submission by the information team. Data Quality dashboards returned from SUS show both the Trusts current standards and national standards.

9. Training

Training for all trust systems is arranged via the IT training Department and all training sessions will ensure staff are aware of the importance of good quality and the timely collection of data.

It is the responsibility of all staff to attend training on any system to which they record data.

It is the responsibility of all managers to ensure that their staff have attended system training.

10. Data Quality Framework

Further information regarding how the Trust manages Data Quality can be found in the Data Quality Framework. This aims to outline an infrastructure which facilitates the implementation of an objective and ongoing cycle of; Monitoring, Measuring and Improvement of data quality for all datasets held within the Trust.

11. Right First Time – Reference Guide

A quick reference guide highlighting some key data quality fields to be aware of is available in Supporting Document 3

12. Policy Review

This policy will be reviewed every 2 years by the Data Quality Manager, unless changes to national requirements are released.

13. Monitoring and Compliance

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this policy.

Trust Policy

Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: <i>(Responsible for also ensuring actions are developed to address any areas of non-compliance)</i>	Frequency of reporting:
WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
Information Governance requirement 506 details the need to have a documented procedure and a regular audit cycle for accuracy checks on service user data. The results of the audits should be reported to the Data Quality Committee and the Information Governance Steering Group	Data Quality Audit Clerk audits national required percentages of staff on a monthly basis	Monthly	Data Quality Audit Clerk	Information Governance Steering Group	Bi-Monthly
Payment by Results Audits: This is a national audit covering inpatients, out patients and coding on a rolling 3 year program.	The Trust will organise an audit of its coded inpatient data. These audits validate the quality of the data recorded on the PAS and the source documentation written in the case notes.	Yearly	External Auditor	Information Governance Steering Group Audit Committee	Yearly
SUS (Secondary Uses Service): Data collected within the Trust is submitted to SUS (monthly/weekly).	Quality checks on this data are performed prior to the submission by the information team.	Monthly/weekly	Information Team	Data Quality Group review the SUS Data Quality dashboards	10 times a year
The information department provide many reports throughout the Trust. These may be for all or some of the directorates, individual departments or ad hoc reports when requested.	Directorate validation of data quality reports such as: <ul style="list-style-type: none"> • 18 week activity • waiting list validation lists • Activity outcomes validation lists • A&E waiting times validation • Patient Master Index DQ • DQ indicators report 	Monthly/weekly	Directorate staff/Directorate validation staff	Reported directly back to directorate managers	Validation is an on-going process
Missing demographic data from PAS	Updating data, such as: <ul style="list-style-type: none"> • NHS Number • PMI Details 	Weekly	Data Quality Clerks	Reported through the Data Quality Group	Validation is an on-going process

14. Equality requirements

The equality impact assessment tool has been completed and shows no equality risks.(Supporting Document 1)

15. Financial Risk Assessment

The financial risk assessment has been completed and shows no financial risks. (Supporting Document 2)

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Appendix 1 – “Right First Time” Reference Guide

1	ALWAYS ASK THE PATIENT to state their: a. Address b. DoB c. Postcode d. GP e. Ethnic origin (if not already on the system) f. NHS number (if not already on the system)
2	Use the ‘INSERT’ facility to change a patient’s address. DO NOT OVERTYPE EXISTING RECORD.
3	Overseas patients - Record overseas address in permanent field.
4	Carry out a thorough check before you register a patient to ensure the patient isn’t on the system. Use the Summary Care Record (SCR) to assist you by using the NHS number in the search.
5	Record new appointments and follow up correctly, using correct clinic type.
6	At the end of each clinic check all patients are on the system with the correct details and have been ‘outcomed’.
7	Ensure any ‘unspecified WL entries’ are updated with full details.
8	Always check you have selected the correct TCI to ensure the correct episode details are recorded for the patient.
9	Check all admission, ward and consultant transfer and discharge details especially recording dates correctly.
10	Only use the transfer transaction when patients move between the 3 acute sites (WRH, ALX & KTC), otherwise the patient should be discharged.
11	Use the ward leave facility to record patients on home leave.
12	Maternity_– Mothers estimated date of delivery MUST be recorded on PAS. Mother and baby episodes need to be linked correctly.
13	Clinical_Coding - If you add a late admission to the system please notify the coding staff on your site.
14	It is essential to ensure notes are retained on the wards for the coders to collect or sent to coding, (whichever is the process for your site).
15	<u>New / Change of Service form</u> – Need to be used to record all new or changes to any activity on Oasis and the Information Department must be copied in regarding all changes. These forms are now available electronically, please refer to the intranet.