Yeovil District Hospital NHS
NHS Foundation Trust

DATA QUALITY POLICY

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Policy Owner	Chief Finance and Commercial Officer		
Author	Head of Data and Analytics		
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Staff/Groups Consulted	Information Governance Steering Group Data Quality Steering Group Policy Group		
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Approved by HMT	Approved by Information Governance Steering Group		
Next Review Due	July 2021		
Policy Audited			
Equality Impact Assessment		July 2018	

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1. RATIONALE

The Trust recognises that all decisions made, whether clinical, managerial or financial need to be based on information, which is of the highest quality. All of the Trust's information is derived from individual data items, collected from a number of sources whether they are captured manually or (more increasingly with the advent of the electronic patient record and electronic health records) on IT systems.

Everyone has a responsibility for data quality and this in turn, should be reflected in all the policies and procedures documented and practised in the Trust by staff at all levels.
In line with Data Protection data must be:

- accurate
- complete - captured in full
- valid (it should be within an agreed format which conforms to recognised national standards)
- timely (collected at the earliest possible opportunity)
- defined - understood by all staff who need to know and reflected in procedure documents
- appropriately sought - collected or checked only once during an episode
- appropriately recorded - in the notes and on the computer system

2. AIMS

The purpose of this policy is to draw together the strands of data quality in an over-arching and reinforcing policy, the principles of which must be reflected in all aspects of the activity carried out within the Trust.

3. DEFINITIONS

SUS The Secondary Uses Service (SUS) is primarily a data warehouse that provides access to anonymous patient-based data for purposes other than direct clinical care such as:

- healthcare planning
- commissioning services
- public health
- national policy development

HES Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England.

4. ROLES AND RESPONSIBILITIES

4.1. Chief Executive and Board of Directors

The ultimate responsibility for use of information and its underlying data quality lies with the Chief Executive and Board of Directors.

4.2. Chief Finance and Commercial Officer

The management of data quality is within the remit of the Chief Finance and Commercial Officer working through the Head of Information and Taunton & Somerset IT Services.

4.3. Directors

Directors are responsible for ensuring processes are in place to capture data accurately. They will ensure routine validation or other procedures are in place to monitor the integrity of the data they collect.

4.4. Clinical Business Unit Managers

Business Unit Managers will nominate a designated member of staff to take responsibility for data quality in their division. They will be responsible for regularly reviewing and maintaining departmental policies and procedures, error corrections and ensuring processes are in place to avoid repeat errors.

4.5. Head of Information

The Head of Information will ensure that business systems and processes are configured to maximise the capture of good quality data, ensuring any issues are recorded in the Trust Risk Register.

4.6. Information Governance Lead

The Information Governance Lead will work closely with the Head of Information and Management Information Team, to promote a data quality improvement culture throughout the organisation to ensure integrity and accuracy of information.

4.7. Information Governance Steering Group

The Information Governance Steering Group will receive routine reports on the standards of Data Quality in the Trust, and monitor the implementation of any recommendations from external authorities. It will be supported in this role principally by the Data Quality Group.

4.8. Data Quality Steering Group

The Data Quality Steering Group is responsible for monitoring and compliance of coding standards with a particular focus on reporting. Monitoring the Trust Risk Register and reporting on the standards of Data Quality in the Trust to the Information Governance Steering Group.

4.9. Clinical Outcomes Committee

The Clinical Outcomes Committee reviews the quality of clinical data through the use of Trust tools such as CRAB and Dr Foster to ensure that external reporting accurately reflects the Trust's standards of clinical care.

4.10. Information Asset Owners (IAO)

Information Asset Owners have responsibility for data quality for electronic or manual information systems. They are responsible for producing and disseminating technical guidance to staff to enable them to record high quality data, for feeding back to staff and managers where there are data quality issues, and working with those staff and managers to rectify the problems

4.11. Designated Staff with Added Responsibility for Data Quality

Designated staff as nominated by Business Unit Managers with added responsibility for data quality will ensure accuracy of data and compliance as directed by Business Unit Managers

4.12. Clinical and Non-Clinical Staff

A fundamental principle of data quality is that data should be right first time, which means that the responsibility is at the point at which it is collected and recorded, whether the recorder is clinical, technical or clerical.
All staff - clinicians, managers, administrative staff and others – will need to recognise these responsibilities as an integral part of their job and profession.

5. PROCEDURES

Procedures provide guidance to staff in handling enquiries about patient information and will also point to the policy/guidance available in other documentation and where they can reference such documents

Procedures identify the need to notify Information Services, Performance Management, and the IT department when changes or new services are introduced. (Appendix 1) Protocol for Data Recording Changes.

Procedures will cover steps to be taken and point to any legislation or other documentation such as the NHS data standards.

There are Trust Policies and Procedures in place and in addition Departmental Operational Procedures will cover each area of data collection. The Departmental Procedures will be discussed and agreed with the Data Quality leads within the Management Information Team

There will be a procedure setting out the processes required to keep 'parallel' databases in step. Without such procedures the Trust, reported activity could be disadvantaged when receiving income. There will be a procedure setting out the method to be adopted by the Trust to ensure that patient care events recorded on computer systems are defined correctly in accordance with the standards set down in the NHS Data Dictionary. The procedure will detail how the Trust will disseminate and update the standards as modified by the Change Control system.

6. CLINICAL CODING

Most clinical data is gathered from documentation completed by clinicians and nursing staff. It is incumbent on them to ensure this is completed in a timely, complete and accurate manner and is suitable for use by coding and administrative staff. This will be audited as part of the Clinical Coding process and the Spot Check Reviews.

Clinical Staff and Clinical Coding staff will work together to further improve the quality of clinical coding. This may be done in the form of agreements with Consultants about appropriate coding for certain operations or coders attending ward rounds or directorate meetings.

Clinical Coding is an important part of the patient data set. Junior doctors, if required, will be offered training sessions to enable their understanding of the importance of this. To achieve this, the following key measures will be in place:

- Clinical Coding Staff will hold regular awareness sessions for Clinical Staff
- Staff will attend any Data Quality, Divisional, Directorate, Clinical Information Groups etc to discuss current coding issues.
- Clinical Coding staff will work with Clinical Staff to ensure a procedure is followed for completing coding prior to a patient transfer/discharge.
- There will be an on-going Clinical Coding internal audit and training programme for all staff.

- The Department Policy and Procedure documents will be regularly reviewed and updated as required to ensure National Standards are maintained.
- There will be an annual Coding Audit by an external agent to ensure accuracy and consistency of coding within the Trust.

7. MONITORING

Data quality will be monitored in order to ensure accuracy and timeliness of data entry, compliance to relevant policies and to assist in developing training programmes.

Monitoring reports will be routinely provided to the CBU Business Managers to action.

The Management Information team will liaise with the Data Quality Groups when routine activity information highlights areas of concern.

It is incumbent on all managers responsible for staff who collect data, to monitor the quality of that data and ensure that staff adhere to the Trust policies and procedures. To aid this there will be monthly reports available on the CIBI Intranet pages. These are designed to enable local responsibility and monitoring of data quality which will be evidenced by the actions taken within the Strategic Business Unit.

Business Unit Managers will also ensure that a mechanism is in place to ensure that their department's documented procedures are reviewed and updated in accordance with the Trust's timescales and clearly when adjustments are made to the method of working.

7.1. Routine Quality Checking

The Trust Information Department runs regular validation routines in line with the Information Strategy. These include:

- Coding Completeness Report
- Trakcare missing Data Reports
- Outcomes or Attendance Reports
- Partial Registration Reports
- SUS Reports
- HES Data Quality Indicators
- Maternity Validation Reports

The strategy of the Trust is to move away from this retrospective checking and correction of data, and strive as far as is possible to identify and eradicate poor practices with robust procedures, additional resources and/or continuation training.

8. TRAINING

The Trust recognises the importance of training to ensure understanding with regard to data quality issues and the responsibility for day to day adherence to policies and procedures rests firmly with the team leaders, supervisors and managers whose areas of responsibilities have been identified. It is their role to ensure that staff are resourced, motivated and listened to in respect to quality issues. Job descriptions should also reflect specific and general responsibilities for encouraging good data quality.

Mandatory training will ensure all staff understand all aspects of the information they collect and how others use data.
Data Quality and Information Governance Training is incorporated within the Trust Training Strategy, and training programmes are reassessed regularly to ensure they meet the needs of staff.

9. LIMITATIONS

This policy applies to staff employed by the Trust, and will be posted with other Policies on the YCloud staff intranet. Patients, visitors and the general public will be made aware of this policy as required.

10. IMPLEMENTATION, MONITORING AND EVALUATION

The implementation, maintenance, and monitoring of this Policy will be managed on behalf of the Trust by the Information Governance Steering Group, who will be supported in this role principally by the Data Quality Steering Group.

APPENDIX 1 – PROTOCOL FOR DATA RECORDING AND SERVICE CHANGES

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

PROTOCOL FOR SERVICE CHANGES THAT AFFECT THE TRUST'S INFORMATION BASE

1. Introduction

The accuracy of the capture and reporting of all patient activity undertaken within the Trust is crucial to the continuing success of the Trust. Patient activity data that is captured on the Patient Administration System (Trakcare) and other departmental computer systems (e.g. RIS and WardWatcher) are used for Statutory Returns to the NHS England, NHS Improvement and financial monitoring of our commissioning contracts with Clinical Commissioning Groups (CCGs).

This activity is used by these bodies and the public to assess the quality of patient care provision at the Trust and for use in National benchmarking and as such it is important to ensure that reported activity is accurate and representative of the actual activity that is being undertaken within each Clinical Business Unit in the Trust.

It is the responsibility of each Clinical Business Unit to ensure that its activity is captured in the most accurate and appropriate manner on Trakcare, including ensuring that the means of capture on Trakcare is representative of the correct patient class (emergency inpatient, elective inpatient, outpatient etc). There are very few instances where patient activity data cannot be entered directly onto Trakcare and where manual paper-based recording of patient activity currently occurs within Clinical Business Unit, this is not counted towards any Divisional activity unless there is an arrangement the Information Department to provide monthly figures.

All changes in service provision, as listed below, must be notified to the Information Department. **Failure to inform the Information Department will lead to inaccurate reporting of Clinical Business Unit activity to the Board of Directors, Department of Health and NHS Improvement and performance against annual plans will be inaccurate and unrepresentative current level of service provision.**

Any queries about the appropriateness and impact of current recording or proposed changes to recording should be raised with the Information Department and Contracting Team, where appropriate, both of which will be pleased to advise further.

2. Changes that require notification:

3. Increase/decrease in beds

- Planned changes to beds to be notified verbally or via email to the Information Department at least 3 weeks prior to change, where possible.
- Unplanned closures (e.g. due to staffing shortages) as soon as possible, verbally or via email to the Information Department.
- Re-opening of beds following any period of closure e.g. following staff sickness, verbally or via email to the Information Department.

4. Increase/decrease in Outpatient Clinics

- Any new Outpatient clinics must be notified to the Outpatient Performance Manager at least 3 weeks prior to commencement. Details will be entered on Trakcare and sent to the Information Department immediately.
- Any cessation of Outpatient clinics must be notified to the Outpatient Performance Manager with at least 3 weeks' notice.
- Any changes to existing clinics will be notified to the Outpatient Performance Manager and a Clinic Instruction/Changes form will be completed and circulated to relevant staff (Appendix 2 attached).
- Protocols for Outpatient Clinic Maintenance – see Annex B attached.

5. Changes in other data recording practices as follows, including activity recording at peripheral sites:

- Any changes from recording patients as daycases to outpatients and vice versa.
- Any changes in recording patients from ward attenders to emergency admissions and vice versa
- Any changes in recording patients as inpatients to daycases and vice versa
- Any changes in recording of Outpatient procedures
- Any cessation in recording of patients onto TRAKCARE and replacement with a manual recording system and vice versa

The change notification form in Appendix 4 should be completed by the Divisional Manager approving the change in recording practice for items listed in 2.3 prior to change being implemented on TRAKCARE.

ANNEX B – TO PROTOCOL FOR DATA RECORDING AND SERVICE CHANGES

PROTOCOLS FOR OUTPATIENT CLINIC MAINTENANCE

1. Clinic Instructions / Change Forms

Changes to Outpatient clinics must be made in writing on the approved Clinic Instruction/Change Form (copy attached) and must contain the following essential information:-

- Consultant and Clinic Codes affected
- Clear instructions concerning what changes are to be made to the clinic(s)
- Date changes are effective from
- Details of any locum cover

Any forms that do not include the required information will be returned and not actioned until received back.

2. Who to Notify

Outpatient Performance Manager must be notified to authorise the changes. Once changes are agreed, copies of the signed form will be circulated to all relevant staff.

3. Annual Leave & Study Leave

Consultant/Medical staff are required to give a minimum of 6 weeks' notice of annual leave and study leave. Failure to comply with this must be notified to the Outpatient Performance Manager and Business Unit Managers.

4. Reinstating Clinics

Requests to reinstate clinics within 7 working days of the session must be checked with the Outpatient Sister before re-instatement, to ensure adequate nursing cover and consulting rooms are available. Outpatient receptionists will require at least 5 working days' notice in writing to reinstate the clinic; this will enable patients to be informed of the appointment and make their arrangements.

5. Reducing Clinics

Requests for reducing the number of patients on a clinic for reasons other than above are required no less than one week before the date of the clinic. Please state the reason for reduction.

6. Locum Cover

It is the responsibility of individual Divisions to keep the Outpatient Sister, Outpatient Performance Manager and Appointment Clerks informed of locum cover.

APPENDIX 2 – CHANGES TO DATA RECORDING PROTOCOL & SERVICE

CLINIC INSTRUCTION/CHANGE

CONSULTANT _____ **SPECIALTY** _____

CLINIC CODE _____ **DAY OF CLINIC** _____

PLEASE LINK ALL RELEVANT LETTERS

DATE OF CLINIC _____

FREQUENCY _____ **CLINIC RUN BY** _____
(Weekly/week in month)

NURSE _____

ROOM _____

OTHER STAFF _____
(i.e Audio/Physio)

NUMBER OF NEW SLOTS		**SLOT CHANGES/DELETIONS**
START TIME		

NUMBER OF F/UP SLOTS		
START TIME		

Signed _____ OP Manager Date Approved _____

Signed _____ Dept Manager

Signed _____ App Support Manager

NOTES

cc: OP Receptionist, Medical Secretary
Information Dept, if relevant

PLEASE CHECK ALL CLINICS FOR ANNUAL LEAVE, STUDY LEAVE, BANK HOLIDAYS & CLINICAL GOVERNANCE

APPENDIX 3 - TO PROTOCOL FOR DATA RECORDING AND SERVICE CHANGES

PROTOCOL FOR NOTIFICATION OF A CHANGE IN DATA RECORDING PRACTICES LISTED IN LIST 2.3 of the Policy.

1. Change notification form

A change notification form must be completed by the Business Unit Manager approving the change and submitted to the Management Information Team prior to the implementation of the change in recording practice on Trakcare – See Appendix 4.

It must contain the following essential information:

Clear instructions concerning what changes are to be made to current recording practices, including:

- Specialty affected
- Clinics/Wards affected, if relevant
- Brief reason for the change in recording practice
- Date changes are effective from and end date, if relevant
- Dated and signed

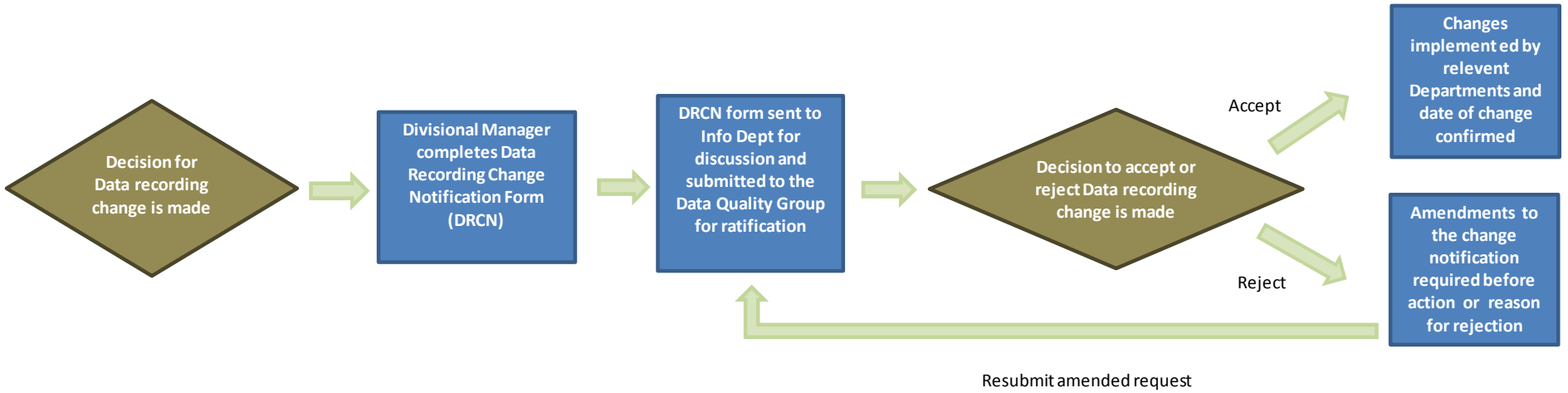
2. Who to Notify

The Management Information Team will submit the Change Notification to the Data Quality Group for discussion. Once the change has been discussed and agreed by the Data Quality Group, the Management Information Team will notify the relevant Departments required to implement the change and monitor the success of the changeover process.

3. Process Flow Diagram

See below.

Process Flow Diagram



APPENDIX 4 - CHANGES TO PROTOCOL FOR DATA RECORDING PROTOCOL AND SERVICE CHANGES. DATA RECORDING CHANGE NOTIFICATION FORM

SPECIALTY _____

CLINIC / WARD, if relevant _____

DATE OF PROPOSED CHANGE _____

DATE OF CHANGE END, if relevant _____

DATA RECORDING CHANGE (please tick):

☐ 1 Daycases changed to outpatients.
☐ 2 Outpatients changed to daycases.
☐ 3 Ward attenders changed to emergency admissions.
☐ 4 Emergency admissions changed to Ward attenders.
☐ 5 Inpatients changed to daycases.
☐ 6 Daycases changed to inpatients.
☐ 7 Outpatients changed to daycases.
☐ 8 Daycases changed to Outpatients.
☐ 9 A change in recording of Outpatient procedures, please provide details in NOTES section.
☐ 10 Cessation of recording of patients onto Trakcare and replacement with a manual recording system.
☐ 11 Cessation of a manual recording system and replacement with recording of patients onto Trakcare.
☐ 12 Other, please specify: _____

RATIONALE FOR CHANGE:

Signed …… CBU Manager Date……..

Signed ……MIT Manager Received on…….

Signed……..CBU Accountant

☐ Impact of changes explained Date Approved……..

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural 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?	N/A	
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 procedural document, please refer it to Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Name: Bernadette Ford Date: 11 July 2018