Data Assurance Policy

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This document is a policy to support the provision and maintenance of high quality data to provide robust clinical information to support the health and business processes of Solent NHS Trust
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Document Sponsor (Name & Job Title)	Chief Information Officer
Document Manager (Name & Job Title)	Head of Data Assurance
Document developed in consultation with	Data Assurance Team, Operations Directors, Head of Information Services, Performance Team, Business and Transformation leads
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
01		4	1.2 Change in wording in response to devolvement of data assurance responsibilities to performance & Information Systems Teams	16/8/2017
02		7	7.4 & 7.5 Change in wording to Data Assurance and Patient Systems Team responsibilities to clarify meaning	15/2/2017
03		9	13 TPP – The Phoenix Partnership	15/2/2017
04		6	7.1 Designated SIRO changed to Chief Operating Officer	15/2/2017
05		3	Executive Summary added	27/09/2017
06		8	7.3 rewording to clarify meaning	27/09/2017

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	Sept 2017			
3	April 2020	Sarah Howarth	Approval as part of the Covid-19 review of policies	Insertion of overarching Emergency Statement and expiry extended to March 2021
4	January 2021	Sarah Howarth	Chairs action - extension to June 2021, policy remains fit and current	

Executive Summary

- The aim of this policy is to set out a clear framework for maintaining and increasing high levels of data quality within Solent NHS Trust.

- The Trust, service users and the public must have confidence in the quality of data used for the provision of patient care, information governance, management and planning, commissioning and accountability.

- Poor quality data can create clinical risk, cause inconvenience to service users and staff, compromise effective decision making and impact on the Trust's ability to monitor standards of care and secure income for its services.

- All staff should be aware of the importance of good data quality and their own responsibility for achieving it. Staff should receive appropriate training in relation to data quality aspects of their work.

- This document applies to staff that have responsibility for collecting, recording or inputting service user based information into the Trust's Key Information Systems.

- Staff with responsibility for data assurance will put in place mechanisms to ensure there is feedback to individual departments and users where necessary on data quality issues. Trust policy is that wherever possible data should be corrected at source.

- Data quality reports will be sent out regularly to clinical, managerial and administrative staff as appropriate. These reports should be used to check for inaccurate, incomplete or untimely data and corrections made in the appropriate clinical system.

- All clinical records systems and clinical documentation related to patient care should use NHS Number as the main patient identifier. Exceptions to this rule are INFORM the Sexual Health System and R4 Dental System

- Users and their managers must accept responsibility for the data they process and input and be prepared to act upon any feedback they receive in relation to changes in data collection or data quality which does not meet the required standard i.e. via data quality reports.

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Staff are expected to adhere to the processes and procedures detailed within this policy. During times of national or 'Gold command' emergency Solent NHS Trust may seek to suspend elements of this policy in order to appropriately respond to a critical situation and enable staff to continue to work in a way that protects patient and staff safety. In such cases Quality Impact assessments will be completed for process changes being put in place across the organisation. The QIA will require sign off by the Solent NHS Ethics Panel, which is convened at such times, and is chaired by either the Chief Nurse or Chief Medical Officer. Once approved at Ethics panel, these changes will be logged and the names/numbers of policies affected will be noted in the Trust wide risk associated with emergency situations. This sign off should include a start date for amendments and a review date or step down date when normal policy and procedures will resume.

1. INTRODUCTION & PURPOSE

1.1 The aim of this policy is to set out a clear framework for maintaining and increasing high levels of data quality within Solent NHS Trust.

1.2 Solent NHS Trust has a responsibility to ensure data is accurate; complies with the Data Protection Act 1998, and is fit for purpose. The organisation has established data assurance roles and responsibilities to drive local processes that ensure good quality. Data assurance leads offer advice and guidance on a variety of data quality issues.

1.3 The Trust, service users and the public must have confidence in the quality of data used for the provision of patient care, information governance, management and planning, commissioning and accountability.

1.4 Poor quality data can create clinical risk, cause inconvenience to service users and staff, compromise effective decision making and impact on the Trust's ability to monitor standards of care and secure income for its services

1.5 In line with Trust policy, an Equality Impact Assessment has been completed. It is understood that this policy will not affect an individual or group of individuals in its application. A copy of the Equality Impact Assessment is included at Appendix A

2. SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy.

2.2 This document applies to staff that have responsibility for collecting, recording or inputting service user based information into the Trust's Key Information Systems.

2.3 "Key systems" refers to all systems, whether paper or electronic, that the organisation uses to collect service user information for the delivery of healthcare. This excludes Independent Contractor Systems but includes all corporate and service specific systems.

3. WHAT IS DATA ASSURANCE?

3.1 The Data Assurance Policy underpins the organisation's objective to record and present data of the highest possible quality and that all users of the information can be confident about its accuracy.

3.2 Data quality is the ability to supply accurate, timely and complete data, which can be translated into information, whenever and wherever, is required. Data quality is vital to effective decision making at all levels of the organisation.

3.3 Supplying accurate data is a complicated task for a number of reasons:

- There are many ways for the data to be inaccurate – data entry errors and missing data, etc.
- Data can be corrupted during translation depending on who is translating it, how and with what tools/processes.
- Data must relate to the correct time period and be available when required.
- Data must be in a form that is collectable and which can subsequently be analysed.

3.4 The following principals are used in assessment of data quality:

- Accuracy: Is the data correct and is it valid?
- Accessibility: Can the data be readily and legally collected?
- Comprehensiveness: Is the relevant data collected and are any data omissions (where intentional or otherwise known) documented.
- Consistency: Are clear and accurate data definitions implemented and adhered to? Do the data definitions define what level of detail is collected?
- Validity: Is the data up-to-date?

4. REQUIREMENTS

4.1 All staff will conform to legal and statutory requirements and recognised good practice, aim to be significantly above average on in-house data quality indicators, and will strive towards 100% accuracy across all information systems.

4.2 All data collection, manipulation and reporting processes by Solent NHS Trust will be covered by clear procedures which are easily available to all relevant staff, and regularly reviewed and updated.

4.3 All staff should be aware of the importance of good data quality and their own contribution to achieving it, and should receive appropriate training in relation to data quality aspects of their work.

4.4 Teams should have comprehensive procedures in place for identifying and correcting data errors, such that information is accurate and reliable at time of use.

5. PROCESSES

5.1 Staff with responsibility for data assurance will put in place mechanisms to ensure there is feedback to individual departments and users where necessary on data quality issues. Trust policy is that wherever possible data should be corrected at source.

5.2 Data quality reports will be sent out regularly to clinical, managerial and administrative staff as appropriate. These reports should be used to check for inaccurate, incomplete or untimely data and corrections made in the clinical system.

5.3 The appropriate department or individual/service must investigate queries, gaps in data items, and anomalies raised by data assurance staff as a result of report production.

5.4 External data quality reports, such as those produced by the Secondary Uses Service (SUS), Open Exeter and NHS Digital, will be checked by data assurance staff and any issues addressed before the next return deadline.

5.5 Internal data quality targets are key for ensuring external targets are met and to also support any local objectives and initiatives. The data assurance staff have developed a set of Data Quality Key Performance Indicators which monitor issues that affect the quality of clinical and performance information across the Trust. These indicators are tracked weekly via the Data Quality Summary Report and monthly via the Data Quality Dashboard. See Appendix B for a definition of each indicator and the impact it has on the quality of our data.

5.6 Completeness & validity checks will be run monthly against specified data items within SystmOne Clinical Records System to check for completeness, consistency and accuracy in accordance with IG Toolkit Requirement 506 and 507. As a minimum the checks will include a sub set from the standards listed in Appendix C. Further information on scoring completeness & validity can be found on the IG Toolkit website.
IG Toolkit Requirement 506
IG Toolkit Requirement 507

5.7 The use of the NHS number as the unique patient/service user identifier will be implemented within all electronic systems and should also be included within manual/paper systems. The NHS number must, where available, be included on all communications with the service user and all clinical communications within and external to the Trust. GU/Sexual Health/HIV patients are exempt as service users have the right to remain anonymous if they so wish. Sexual Health and Dental system use an auto-generated inform number as an alternative ID number.

6. CLINICAL CODING

6.1 There are established procedures in place for the audit of clinical coding from the patient medical record and discharge summaries. Details can be found in the Solent FCE Clinical Coding Standard Operating Procedure.

6.2 An external agency is contracted each year to undertake an annual audit of the trusts clinical coding. The results of this audit contribute to the Trusts overall IG rating. This is supported by a quarterly internal clinical coding audit cycle agreed with commissioners as part of Solent's Data Quality Improvement Plan (DQIP)

6.3 The Trusts clinical coder runs regular clinical coding reports to identify missing codes and works closely with services to locate relevant diagnostic and procedural information.

6.4 The Clinical Coder attends refresher training every 3 years and as appropriate following new releases of ICD10 and OPCS-4.

7. ROLES & RESPONSIBILITIES

7.1 The Chief Executive is the Accountable officer for Data Assurance. However the management of Data Assurance has been delegated to the Chief Operating Officer who is the designated Senior Information Risk Officer (SIRO).

7.2 Managers & Heads of Departments are to:

- Ensure all users are able to attend training/refresher sessions when requested by their line manager
- Ensure all users understand the importance of data quality
- Ensure all staff have the opportunity to attend SystmOne User Groups or other meetings where data quality is discussed when requested by their Line Manager
- Ensure that data quality reports are actioned by the user responsible for the error in a timely manner

7.3 All clinical system users should have the opportunity to:

- Attend training/refresher courses when requested by their Line Manager
- Attend data quality awareness sessions when requested by their line manager
- Attend SystmOne User Groups meetings when required by their line manager
- Correct any data quality errors that are returned to them in a timely manner

7.4 Staff with responsibility for data assurance should:

- Interpret the requirements of the NHS Data Dictionary and Data Manual to ensure clinical systems are configured in accordance with statutory requirements where mandated and not a hindrance to delivery of safe patient care
- Produce regular data quality reports for Managers, Department Heads and users for action. See Appendix D – Viewpoint Data Assurance Reports
- Provide regular data quality awareness sessions for staff when requested
- Be the main point of contact for users with queries on data quality
- Return service user level data quality errors to staff for correction in a timely manner
- Monitor and review the underlying data supporting the Trusts Key Performance Indicators providing regular Data Quality RAG ratings for each measure

7.5 The Patient Systems Team should:

- Be responsible for configuring clinical systems
- Support staff with responsibility for data assurance in ensuring clinical systems are configured to comply with mandated NHS Data Dictionary and Data Manual statutory requirements
- Where possible support clinical services in providing robust data collection templates
- Be aware of and comply with legislation and Trust policies and procedures
- Work in partnership with operational services and staff with responsibility for data assurance to improve data quality

7.6 The Performance Team should:

- Work in partnership with operational services and staff with responsibility for data assurance to improve data quality
- Work with staff with responsibility for data assurance, validating queries supporting the Trusts contractual key performance indicators

7.7 The responsibility for accurate and timely recording of patient data rests with all members of staff, particularly the originator of the record. All staff should:

- Be aware of the importance of good quality data. As Solent NHS Trust has implemented a spine compliant clinical records system it is even more imperative that data is collected and reported accurately first time.
- Have data quality commitments clearly set out in job descriptions and person specifications, for whatever role staff hold i.e. administrative, clinical, managers etc so staff are fully aware of their responsibilities as an integral part of their role and profession.
- The Trust must be committed to providing appropriate support to staff to enable them to meet predefined data quality standards by:
  - Being explicit about what is expected
  - Providing appropriate training facilities and on-going support and materials
  - Feeding back to users on their performance through regular data quality reports

7.8 Users and their managers must accept responsibility for the data they process and input and be prepared to act upon any feedback they receive in relation to changes in data collection or data quality which does not meet the required standard i.e. via data quality reports. Such reports can provide a manager with invaluable feedback on potential areas or users which require further support and training.

7.9 Wherever feasible all data corrected must be made at source within agreed timescales preferably by the original user thus helping to reinforce the training and data quality message and improve data quality for the future.

8. TRAINING

8.1 Staff should be trained in the use of all information systems commensurate with their roles. It is the Trust's duty to ensure that staff are given the appropriate opportunities for training and the responsibility of line managers to ensure that training is taken up.

8.2 Instruction should be given to staff to ensure that all records are consistent. The NHS Data Dictionary is complex and detailed and simple instructions to staff on appropriate interpretation should be provided through systems training, documentation and advice from the Information Department.

8.3 Training in key information systems will be delivered via a short module on data quality and any refresher training to ensure all users are aware of the importance of data quality and gain a wider perspective than their specific role on what data they collect and input is used for. The SystmOne User Groups provide an ideal opportunity for this.

9. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

9.1 A copy of the Equality Impact Assessment is available at Appendix A.

9.2 This policy will ensure all service users' clinical information is monitored for accuracy and completeness and actions taken to correct inaccurate and incomplete data

10. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

10.1 Staff with responsibility for data assurance will monitor the effectiveness of this policy, via weekly and monthly analysis measuring the performance against key data items as defined by NHS Digital, local reporting and the Data Quality Improvement Programme.

10.2 Summary reports are circulated weekly and monthly to selected Senior Managers and Directors. Detailed data quality reports are circulated to clinical teams for correction and the Data Quality Improvement Plan is discussed monthly at the CSU (Commissioning Support Unit) Information Sub-Group.

11. REVIEW

11.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review. This policy will remain in force until such time as a new one is formally agreed.'

12. REFERENCES AND LINKS TO OTHER DOCUMENTS

12.1 IG Toolkit
NHS Data Dictionary
NHS Digital

12.2 Clinical Coding Policy
Solent Data Audit Plan 506
Data Quality Improvement Plan
Completeness and Validation 507 Procedure

13. GLOSSARY

CQC	Care Quality Commission
CRS	Clinical Records System
CSU	Commissioning Support Groups
DQIP	Data Quality Improvement Plan
HCP	Health Care Professional
HES	Hospital Episode Statistics
IAC	Information Asset Custodian
ICD 10	International Classification of Diseases v10
IG	Information Governance
IQAP	Information Quality Assurance Programme
OPCS 4	Office of Population Censuses and Surveys – Classification of Interventions and Procedures version 4
PbR	Payment by Results
PAS	Patient Administration System
PSC	Performance Sub-Committee
QPR	Quality Risk Profiles
S1	SystmOne – Solent NHS Trust's primary clinical records systems
SIRO	Senior Information Risk Officer
SUS	Secondary Users Services
TPP	The Phoenix Partnership - name of the SystmOne clinical system supplier

Appendix: A Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	Answer		
1. What are the main aims and objectives of the document?	To ensure that there is a fair and consistent approach to managing Data Quality within Solent NHS Trust		
2. Who will be affected by it?	All staff		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	98% Completeness for Trust Data Quality Key Performance Indicators 96% NHS Digital National Data Quality Score		
4. What information do you already have on the equality impact of this document?	None		
5. Are there demographic changes or trends locally to be considered?	No		
6. What other information do you need?	None		
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document discriminate unlawfully against any group?		x	The policy ensures all staff are treated in a consistent manner
2. Can any group benefit or be excluded?		x	The policy ensures all staff are treated in a consistent manner
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	The policy ensures all staff are treated in a consistent manner
4. Can this actively promote good relations with and between different groups?	x		Due to the consistency of approach everyone will be treated equally
5. Have you carried out any consultation internally/externally with relevant individual groups?		x	None required
6. Have you used a variety of different methods of consultation/involvement		x	None required
Mental Capacity Act implications		x	None
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		x	No

If there is no negative impact – end the Impact Assessment here.

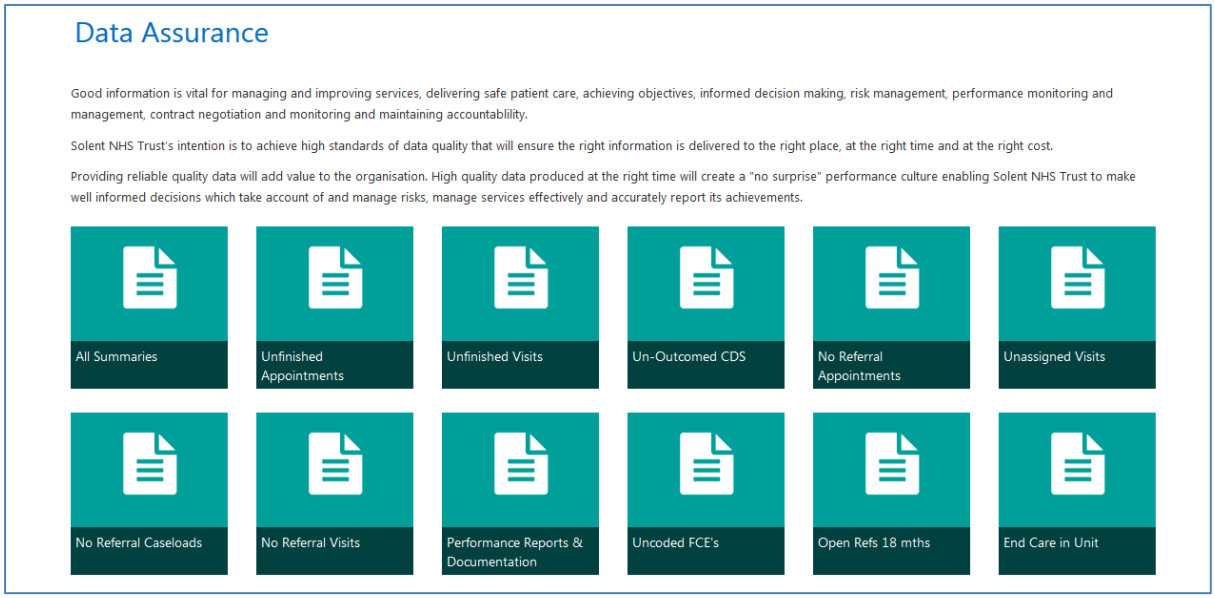
APPENDIX B Data Quality Key Performance Indicators

Indicator	Description	Impact
Unfinished Appointments	Appointments that have been left in a booked state and have not been Finished and Outcomed in the Clinic Rota in SystmOne	Impacts on waiting time performance and activity and productivity monitoring. Appointments that have not been Finished and Outcomed cannot be reported as having taken place.
No Referral Appointment	Appointments that have been booked but are not linked to the appropriate referral	It is not possible to measure waiting times or allocate the activity to a team or caseload for reporting. A services performance and productivity will look low against previous month's data. Gives a false impression of demand within a service. Lack of reliable waiting time data means that patients could breach targets and wait unacceptably long periods for an appointment. Impacts on patient experience.
No Referral Visit	Visits that have been booked but not linked to the appropriate referral	As above. Although similar these two indicators are monitored separately as the process for managing in SystmOne are different
Incomplete Visit	Visits that have been left in a requested state and have not been Finished and Outcomed in SystmOne	Waiting times will be affected – waits will look longer than actual. Poor performance will be highlighted in performance dashboards. Activity and workload will be under reported giving a false impression of demand within a service
Unoutcomed CDS	Appointments with no Outcome recorded. This is specific to those Units in SystmOne with CDS functionality switched on	Effects completeness of data sent to HSCIC (Health & Social Care Information Centre) via Commissioning Data Set. Impacts on Trust overall data quality rating as published by HSCIC.
Unassigned Visits	Visits that have not been assigned to a health professional	Unable to report the activity against the correct staff member and team which will result in under-reporting of activity. Patients could be missed and not followed up impacting on poor patient experience and potential risk to the patient.
Referrals No Caseload	Patients that do not have a caseload linked to their referral	Impacts on ability to link activity to teams and HCPs for reporting

Appendix C IG Toolkit 507 – Key Data Items Output Quality Standards

		Weighting	% Complete and Valid Minimum to Score				
Data Set	Key Data Item	Multiply achieved score by 1 or 5	2	4	6	8	10
Inpatients	NHS Number	5	92	93.5	95	96.5	98
Inpatients	NHS Number Status	1	92	93.5	95	96.5	98
Inpatients	Postcode	5	96	97	98	99	100
Inpatients	Ethnic Category	1	85	87.5	90	92.5	95
Inpatients	GP Practice Code	1	97	97.5	98	98.5	99
Inpatients	Birth Date	1	97	97.5	98	98.5	99
Inpatients	Sex	1	97	97.5	98	98.5	99
Inpatients	Admin Category	1	97	97.5	98	98.5	99
Inpatients	Patient Class	1	92	93.5	95	96.5	98
Inpatients	Admit Date	1	97	97.5	98	98.5	99
Inpatients	Admin Method	5	97	97.5	98	98.5	99
Inpatients	Admin Source	1	97	97.5	98	98.5	99
Inpatients	Discharge Destination	1	92	93.5	95	96.5	98
Inpatients	Discharge Method	1	92	93.5	95	96.5	98
Inpatients	Discharge Date	1	97	97.5	98	98.5	99
Inpatients	Last episode in spell	1	97	97.5	98	98.5	99
Inpatients	Episode start date	1	97	97.5	98	98.5	99
Inpatients	Episode end date	5	97	97.5	98	98.5	99
Inpatients	Decided to admit date	1	97	97.5	98	98.5	99
Inpatients	Intended management	1	92	93.5	95	96.5	98
Inpatients	Consultant code	1	97	97.5	98	98.5	99
Inpatients	Treatment Function code	1	97	97.5	98	98.5	99
Inpatients	Primary diagnosis	1	91	93	95	97	99
Inpatients	Operation status	1	91	93	95	97	99
Inpatients	Primary procedure date	1	91	93	95	97	99
Inpatients	HRG code	1	91	93	95	97	99
Inpatients	Critical care start date	1	91	93	95	97	99
Inpatients	Critical care discharge date	1	91	93	95	97	99
Outpatients	NHS Number	5	92	93.5	95	96.5	98
Outpatients	NHS Number Status	1	92	93.5	95	96.5	98
Outpatients	Postcode	5	96	97	98	99	100
Outpatients	Ethnic Category	1	85	87.5	90	92.5	95
Outpatients	GP Practice Code	1	97	97.5	98	98.5	99
Outpatients	Birth Date	1	97	97.5	98	98.5	99
Outpatients	Sex	1	97	97.5	98	98.5	99
Outpatients	Admin category	1	97	97.5	98	98.5	99
Outpatients	Source of referral	5	91	93	95	97	99
Outpatients	Referral received date	1	91	93	95	97	99
Outpatients	Attend/DNA	5	91	93	95	97	99
Outpatients	First Attend	1	91	93	95	97	99
Outpatients	Outcome of attendance	1	91	93	95	97	99
Outpatients	Attendance date	5	91	93	95	97	99
Outpatients	Consultant code	1	91	93	95	91	99
Outpatients	Treatment function code	1	91	93	95	91	99

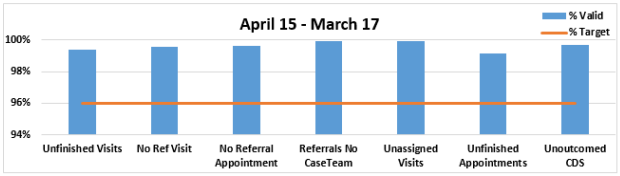
Appendix D – Viewpoint Data Assurance Reports



Data correct as at 2017-02-12

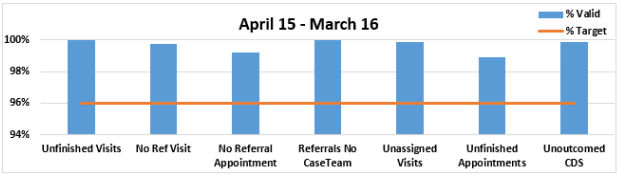
April 15 - March 17

Row Labels	Total Valid	Total Invalid	Total Records	% Valid	% Target
Unfinished Visits	1077893	6741	1084634	99.38%	96%
No Ref Visit	1090061	4657	1094718	99.57%	96%
No Referral Appointment	758656	2989	761645	99.61%	96%
Referrals No CaseTeam	244453	118	244571	99.95%	96%
Unassigned Visits	1083611	1023	1084634	99.91%	96%
Unfinished Appointments	726079	6474	732553	99.12%	96%
Unoutcomed CDS	548513	1612	550125	99.71%	96%
Grand Total	**5529266**	**23614**	**5552880**	**99.57%**	**96%**



April 15 - March 16

Row Labels	Total Valid	Total Invalid	Total Records	% Valid	% Target
Unfinished Visits	590271	161	590432	99.97%	96%
No Ref Visit	589029	1403	590432	99.76%	96%
No Referral Appointment	368188	2937	371125	99.21%	96%
Referrals No CaseTeam	159122	19	159141	99.99%	96%
Unassigned Visits	589740	692	590432	99.88%	96%
Unfinished Appointments	367166	3959	371125	98.93%	96%
Unoutcomed CDS	259747	377	260124	99.86%	96%
Grand Total	**2923263**	**9548**	**2932811**	**99.67%**	**96%**



April 16 - March 17

Row Labels	Total Valid	Total Invalid	Total Records	% Valid	% Target
Unfinished Visits	487622	6580	494202	98.67%	96%
No Ref Visit	501032	3254	504286	99.35%	96%
No Referral Appointment	390468	52	390520	99.99%	96%
Referrals No CaseTeam	85130	99	85229	99.88%	96%
Unassigned Visits	493871	331	494202	99.93%	96%
Unfinished Appointments	358913	2515	361428	99.30%	96%
Unoutcomed CDS	288766	1235	290001	99.57%	96%
Grand Total	**2605802**	**14066**	**2619868**	**99.46%**	**96%**