Data Quality Policy
(F-021)

Version Number:	4.4
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Executive Lead (name & job title):	Peter Beckwith, Director of Finance
Name of approving body:	Information Governance Group
Date full policy approved:	December 2016
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Next Full Review date:	November 2025

Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*Peter Beckwith – 28 November 2022*
Date EMT as approving body notified for information:	*November 2022*

<u>Policies should be accessed via the Trust intranet to ensure the current version is used</u>

Contents

1. INTRODUCTION

Humber Teaching NHS Foundation Trust recognises the importance of reliable information as a fundamental requirement for the effective treatment of service users and decision making. As the Trust moves from block contracts to Payment by Results, closer working with partner organisations and the sharing of electronic patient records it is vitally important that accurate data of all clinical activity is recorded electronically. Data quality is crucial and the availability of complete, accurate and timely data is vital in supporting patient care, clinical governance, management, performance targets, KPIs, CQUINs and service agreements for healthcare planning and accountability.

Like all businesses, Humber Teaching NHS Foundation Trust must ensure that the income it generates does not fall below the cost of providing these services to an acceptable quality. The Trust also recognises the responsibilities its practitioners have for written and/or electronic record keeping as required by practitioners' professional codes of conduct.

This policy relates to other Trust policies, identified in paragraph 11.

2. SCOPE

This policy outlines good practice and details the responsibilities of all staff regarding the quality and timeliness of all data. The policy applies not only to clinical information but also to information used for the purposes of administering services to patients and financial and managerial decision making.

Everyone within the Trust has a responsibility for ensuring high quality data.

3. POLICY STATEMENT

The Trust has a legal duty to ensure that the data it records is timely, accurate and up-to-date in line with the fourth principle of the Data Protection Act 2018 and General Data Protection Regulation. The Trust also has an ethical duty to its staff and service users to ensure that the data recorded in all records is timely, accurate and fit for the purpose for which it is intended.

Data quality will be embedded in performance and risk management arrangements, with regular assessment of service performance as well as risks associated with unreliable or inaccurate data.

4. DUTIES AND RESPONSIBILITIES

4.1 Chief Executive
The chief executive has overall responsibility for data quality within the Trust. As the accountable officer he/she is responsibility for ensuring appropriate mechanisms are in place to support the delivery of this policy.

4.2 Director of Finance and SIRO
Designated member of staff with Board-level strategic responsibility for data quality supported by the Trust's chief information officer.

4.3 Chief Information Officer
Will take the lead in ensuring that data quality objectives are articulated and that there are mechanisms in place to measure Trust performance against these objectives.

4.4   Head of Information Governance
Responsible for ensuring the Data Quality Policy meets the requirements as specified in the Information Governance Toolkit.

4.5   Information Management Team
- Interpret requirements of the Data Dictionary and Data Manual to ensure compliance of all Trust data
- Monitor and disseminate changes to requirements as notified via DSCNs or other official channels
- Ensure that all systems support robust data collection, reporting any issues for action regarding training issues etc.
- Produce regular reporting and enable production of exception reporting to monitor improvement or deterioration in data quality
- Work with colleagues in ops & Digital Team to produce reports for services where issues have been identified
- Act appropriately on any data quality issues in a timely manner
- Be aware of and comply with legislation and Trust policies and procedures
- Querying the Trust's patient management systems to generate robust reports, and highlighting anomalies and data quality concerns to Information Governance and/or trust services

4.6   Performance Management Team
Develop and maintain performance monitoring framework and track the Trust's performance against agreed targets within key indicators

4.7   Information Governance Group
Responsible for agreeing and mandating the Trust data quality objectives and ensuring that they are linked to the Trust's business objectives.

The group will be responsible for monitoring performance against these objectives and ensuring that any risks associated with data quality are duly reported to the Trust Risk Register.

4.8   Data Quality Group
Reporting directly to the IG Group the main focus of the Data Quality Group is to ensure the data quality objectives are monitored and mechanisms put in place to ensure these are achieved. Data Quality Maturity Index (DQMI) reports produced by NHS Digital and Data Quality Improvement Plans (DQIP) will be standing agenda items at the meeting and any issues will be discussed and remedial action put forward for Senior Management sign-off. Any major areas of concern will be escalated to the IGC.

4.9   Divisional Information Officers/Nominated DQ Leads
Responsible for communicating Data Quality Policy and procedures and monitoring and ensuring adherence to standards within their Care Group.

4.10   Managers and Head of Departments
Responsible for ensuring all their staff are fully aware of their obligations to maintain complete, accurate and timely records. All managers will monitor data quality on a regular basis. This will form part of all business meetings and management supervision, identifying if there are any gaps in data from clinical staff, to ensure that all staff are accurately recording all clinical activity undertaken and ensure DQ report are used and acted on. Managers should ensure staff entering/recording data are adequately trained in areas of the systems they use and advised of the cause and effect of entering poor quality data (eg waiting list clock start/stops)

4.11 All staff
- Be aware of their personal responsibilities with regards to data quality for any information which they create, use or process
- Ensure IG training is completed at least annually

4.12 Individual Clinical Staff
- Protect time every day to ensure that all clinical activity is recorded daily. This will ensure the timely, accurate and complete input of their own clinical data
- If unable to record activity due to competing priorities, ensure that all activity is recorded on the system within 24 hours of occurrence
- Regularly check service user demographic data with service users and ensure the update of any inaccuracies
- Ensure caseloads are regularly checked and updated
- Monitor and escalate any data quality issues appropriately
- Be aware of and comply with legislation and Trust policies and procedures
- Monitor own competencies and access appropriate training where necessary

4.13 Administrative staff inputting on behalf of clinicians
- Ensure timely, accurate and complete input of data from clinical notes or completed forms
- Resolve any issues of data recording with the appropriate clinician
- Update any inaccuracies in service user demographic data
- Monitor and escalate any data quality issues appropriately to their line manager
- Be aware of and comply with legislation and Trust policies and procedures
- Monitor own competencies and access appropriate training where necessary

4.14 Digital Team/System Administrators
- Ensure systems are configured to NHS Data Dictionary standards where applicable
- Produce/provide appropriate system training material & documentation for users to mitigate against inadequate data quality
- Keep training material up to date and relevant to current standards
- React and implement changes when issues are raised via DQ Group or other forums

5.   PROCEDURES

5.1   Definitions
The key characteristics for good quality data are as follows:

5.1.1   Valid
This means that data conforms to recognised standards or formats, either national or local (the NHS number will always have ten digits for example). Computer systems should be programmed to error-trap invalid entries.

5.1.2   Complete
This means the data is captured in full. Systems should be programmed to force the input of mandated fields.

5.1.3   Accurate
This means that the data matches exactly to the true values of the correct information. So for example, information held on computer systems always matches what is in the manual record. Always check data with the source, for example checking a service user's address when they attend an appointment.

5.1.4   Timely
This means that data is recorded and available as soon after the event as possible. Inputting

details of contacts and interventions makes that information available to all practitioners providing care to the service user.

All data should be recorded within specified deadlines being entered at or as near as possible to the event being recorded. This will ensure that data required for both primary reasons (i.e. patient's clinical record and, therefore, care) and secondary reasons (i.e. statutory returns & data sets and performance information) is the most up to date available.

5.1.5 Relevant

This means the degree to which the data meet current and potential user's needs. Data should only be collected for a specific purpose and no more.

5.1.6 Consistent

This means that data items should be reliable and internally consistent. Where standard codes are used, these should be recorded consistently across systems.

5.1.7 Coverage

This means complete data capture so that data will reflect all the work carried out by Trust staff. Spot checks, exception reports and audits will be used to identify missing data and these will be followed up within agreed time scales.

5.2 Training and Awareness

Regular exception reporting, careful monitoring and error correction can support good quality data but it is more effective and efficient for data to be entered correctly first time.

In order to achieve this, the importance of the Trust's commitment to data quality should be established at the commencement of employment. The importance of data quality and basic data quality measures are covered in all Information Governance Training Sessions. This must be supported by system specific training, through Induction programmes and on the job training for all new staff.

Staff should have a clear understanding of the following:

- The definitions of individual data items, so that they understand what they are recording
- The function of data items, so that they know why they are recording data items
- How to validate data with the patient or against other records, so that they know they are recording the correct data
- The correction of errors, so that they know how to correct errors and how to report errors if they find them
- The use of data, so that they understand what the data they are records is to be used for and therefore why accuracy is important.

Corporate Data Quality objectives will be included in updated job descriptions for all staff. Delivery of these responsibilities will be assessed as part of the annual staff performance and development review.

5.3 Identifying and Correcting Errors and Omissions

The Trust will as a matter of routine, monitor performance in collecting and processing data according to defined standards and provide feedback to staff.

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

Some practical guidance is given in Appendix 1.

Data quality issues can be raised as agenda items at the DQ Group or discussed in other suitable forums (user grouos, systems meetings). Any serious issues should be raised as soon as possible via the IT Service Desk.

5.4   Data Quality Objectives

The Trust data quality objectives will be linked to the Trust's business objectives and will be determined from a number of sources:

- Department of Health and Social Care
- NHS Improvement
- Commissioners
- Care Quality Commission
- Data Quality Audits
- Information Governance Toolkit
- Payment by Results
- Projects and Pilots, for example Payment by Results

A number of initiatives are in place to ensure that the quality of high level indicators reported are maintained, namely:-

- Seven-day follow-up post discharge from inpatient setting
- Delayed discharges
- Gatekept admissions
- Access and waiting times

Completeness and validity checks of data submitted to SUS and other Department of Health Departments will be undertaken and reported to the relevant governance and performance committees. External validation tools will be used to determine the quality of data held centrally (e.g. SUS Data Quality Dashboards, MHSDS DQMI reports produced by NHS Digital).

The objectives will be agreed and mandated by the Information Governance Committee. Achievement against these objectives will be monitored by the Data Quality Group with a quarterly report being submitted to the Information Governance Committee.

6.   EQUALITY AND DIVERSITY

The Trust aims to ensure that all of its policies are equitable with regard to age, disability, gender, race, religion and belief or sexual orientation.

An Equality Impact Assessment has been carried out by the author which confirms that this policy does not impact on any equality group (Appendix 4).

7.   MENTAL CAPACITY

This is a non-clinical policy therefore not relevant.

8. BRIBERY ACT

For further information see www.justice.gov.uk/guidance/docs/bribery-act-2010-quick-start-guide.pdf.

If you require assistance in determining the implications of the Bribery Act please contact the Trust Secretary on 01482 389194 or the Local Counter Fraud Specialist on telephone 0191 441 5936 or email counterfraud@audit-one.co.uk.

9. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Sheet (Appendix 3).

The implementation of this policy requires no additional financial resource.

This policy will be disseminated by the method described in the Policy for the Production, Approval and Review of Policies.

10. MONITORING AND AUDIT

The framework for monitoring and reviewing data quality will be through the annual Information Governance Toolkit submission and improvement plan and by the quarterly monitoring reports to the Information Governance Group as described in paragraph 5.4. Regular monitoring will occur throughout the course of the year using the Data Quality Improvement Plans (DQIP) and processes we have with our Commissioners.

11. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Information Governance Toolkit www.igt.hscic.gov.uk
NHS Data Standards http://content.digital.nhs.uk/standards
NHS Data Dictionary http://www.datadictionary.nhs.uk
NHS Digital www.digital.nhs.uk
SUS http://content.digital.nhs.uk/sus

Related Trust policies and guidance:

- Information Governance Policy
- Health and Social Care Records Policy
- Caldicott and Data Protection Policy
- Safe Haven Policy
- Freedom of Information Policy
- Access to Health Records Policy
- Information Governance Training Policy
- Information Security Policy
- Confidentiality Code of Conduct

This policy is not an NHSLA requirement.

Appendix 1: Guidance on Data Quality and Correct Identification of Service Users

INTRODUCTION

This guidance is aimed at all staff who are responsible for or involved with registering or identifying service users. This can be within a therapeutic or clinical environment, for instance administering medication on a ward, or in an administrative setting, for instance recording that a service user has attended for an appointment.

This guidance contain some of the key actions required by staff which will enable the Trust to discharge its responsibilities and manage risk (both clinical and non-clinical) associated with data quality and the correct identifications of service users.

PROCEDURES

Registration
All service users will be identified and registered onto the Trust's electronic care records systems as near as possible to their first contact with the Trust. This will be by means of the Clinical Spine Application as described in the NHS Care Records Service Clinical Spine Application User Guide and the Trust's NHS Number Strategy available on the intranet.

If the service user is unable to give details about themselves, for example if they are too ill or do not have the capacity, then details should be taken from the person who is accompanying them. In some rare instances the service user may be unable to give details about themselves and are not accompanied by anyone. The admitting unit should consider making contact with the police in these cases to establish for example, if they have been reported as a missing person.

Naming Conventions
Trust staff should be aware when tracing or registering a service user of non-standard spellings of forenames and surnames (e.g. Mark or Marc, Davis or Davies).

For some ethnic communities, Western naming conventions do not apply. Hindus may adopt new complementary names as they reach adulthood or get married; for Muslims, the order of the names may not necessarily be fixed or significant.

Wherever possible, the service user's name should be transcribed from printed documentation either provided by the patient or the GP, rather than handwritten forms.

When a search for a service user is carried out on systems, ensure that the process is followed as described in the appropriate system user manual available from the Trust Intranet.

Validation
Validation and ongoing checks should be done throughout the service users care episode. When you receive a referral, if there is any doubt of the service user's details, contact the GP. The GP should have checked all demographic details with the service user prior to submitting the referral, therefore the referral itself should detail the correct information.

Staff who regularly come into contact with service users should check their personal details with them if they have not been seen for a while and ensure any inaccuracies or out of date information is updated in the health records and on Trust systems.

Staff should always refer to the information held on Trust systems as the authorised source of accurate information, for example if contacting a service user by telephone or by letter.

Ask the service user to confirm their name, address and date of birth every time they present themselves for an outpatient appointment. In an inpatient unit setting ask the service user to give their full name if you are not familiar with them. When approaching a service user you do not

recognise, ask them their full name rather than saying "Are you John?"

To avoid updating the wrong case notes avoid having more than one set of files open at any time. The top of each sheet or document in the notes should identify the service user with their name, NHS number and unit number.

The Medical Records Department will regularly produce reports from systems regarding potential duplicate records and deal with these according to their internal procedure. If two service users have the same or very similar names, or a combination of same or similar names and dates of birth, the Medical Records Department will endorse the front cover of the case notes with a label saying "Caution, another patient has the same or a similar name."

Service users who give misinformation
There are a small number of service users who may attempt to conceal their identity by deliberately giving false information. These may be difficult to detect but suspicions may be raised because of inconsistencies in their presentation. Examples of this might be anything from a regional accent that does not fit their history to a slight discrepancy in the given date of birth or name. A practitioner may recognise a service user from previous contacts, yet there are no previous notes for them.

Often merely raising these suspicions with the service user will be sufficient to encourage them to give the correct information.

Other cases may be more difficult to establish or detect and you may want to seek the opinion and advice of a colleague or your line manager.

Depending on the background, websites such as the Missing Persons Helpline (www.missingpeople.org.uk) can be accessed also the Communications Department receives alerts regarding service users from other Trusts who may turn up in our area.

If the service user is determined to intentionally give false information there are limits to what steps can be taken to mitigate against this. However, all service users should be informed at the outset about the importance of giving correct, accurate information and this is explained on the patient information leaflet Your information – our key to your best health and social care.

NHS NUMBER

The Trust will ensure that service user records, both paper and electronic, have an NHS number stored on them as early as possible in the episode of care. Staff should be routinely using the NHS number as part of the provision of care, to link the service user to their care record, to communicate within and between organisations and ensure service user awareness of the NHS number.

The National Patient Safety Agency (NPSA) published a Safer Practice Notice (SPN) for the NHS Number in September 2008 which mandated the use of the NHS number as the national patient identifier. The NHS number must be included with other demographic information as part of safe practice to link together the correct records to a particular service user.

General NHS Number Principles

1. **Find It** – find the NHS number for a person as soon as possible in the care pathway, ideally on initial contact with the service:

   - find/request the NHS number on referral letters/forms received;
   - determine and verify the NHS number before or at the start of an episode of care;
   - if this is not possible then tracing should be performed as early as possible in the episode either at point of contact or as a back-office process.

2. **Use It** – use the NHS number to link a person to their health/care record:

    - use the NHS number to search for an electronic record as the "first choice";
    - use the NHS number to identify people presenting for care;
    - include the NHS number on electronic records, wristbands, data that are used for that person's care;
    - use the NHS number as the key identifier for service users;
    - ensure systems can support the NHS number;
    - use the Personal Demographics Service (PDS) or Demographics Batch Services (DBS) to trace NHS numbers.

3. **Share It** – share the NHS number with other departments and organisations so they can use it:

    - include in all communications – written, verbal and electronic – during telephone calls, on all letters, referrals, forms, documents;
    - internally within the Trust and with all other organisations you contact as part of the provision of care;
    - ensure the NHS number is included when providing service users with any letters or forms;
    - supply the NHS number as the key identifier for any patient identifiable data that passes across systems and organisation boundaries.

4. IT systems that do not support the principles must not be procured (this has been a requirement since 30 June 2009).

5. Staff dealing with service users including receptionists and clinical/care staff should, where possible, use the NHS number to identify service users. If the service user does not present with an NHS number then staff must, where possible determine and verify the NHS Number at or immediately after the initial contact with the service user.

Maintain Prevalence
The Information Management Department will run monthly reports showing completeness of the NHS number.

Completeness of NHS number will form part of the monitoring and performance reports provided to the Information Governance Committee as part of the data quality monitoring.

Training and Awareness
The Trust will deliver individual training on the use of or access to the Clinical Spine Application to all staff, both new and existing whose job role includes the identification and registering of service users on the Trust's patient administration system. This will include the provision of written procedural documentation on these processes. This documentation will be regularly reviewed by the Trust IT training lead. Records of this training will be kept.

Appendix 2: Timeliness Standards for Data Entry

Registrations should be entered onto the systems within one working day of receipt of the referral.

Outpatient attendances and Community Contacts
Where clinical data entry occurs, entries should be made onto systems within one working day of the event having taken place.

Where data is sent to a central point, for example, to specific data entry staff, or is to be inputted by non-clinical staff such as medical secretaries, this data should be sent by the clinicians on a daily basis within one working day of the event having taken place. The data should be entered by administration staff onto the system as soon as possible after receipt and any potential backlog reported to the line manager.

Inpatients
Inpatient admissions, transfers and discharges should be entered onto systems on the same day as the event takes place.

Clinical coding of inpatient spells should be completed as soon as the discharge letter is available.

Data unavailable at time of event
In circumstances where information is not available at the time of the event e.g. during an admission where the patient is unable to provide their personal details, this should be followed up within five working days of the event and both manual and electronic records updated accordingly.

Where there are problems in achieving the timeliness standards listed above, this should be reported to the line manager and identified data quality leads for the area and action taken to resolve the particular problem.

Reports on timeliness of data entry will be made available to managers and to appropriate monitoring groups. Where there are persistent problems, formal improvement action plans should be developed, agreed at an appropriate level within the Trust and improvement monitored.

Appendix 3: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Data Quality Policy
Document Purpose	This policy outlines good practice and details the responsibilities of all staff regarding the quality and timeliness of all data. The policy applies not only to clinical information but also to information used for the purposes of financial and managerial decision making.

Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates			
Approving Committee:	IG Group	Date of Approval:	18 September 2018
Ratified at:	N/A (minor amends)	Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [ ]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This policy will be disseminated by the method described in the Policy for the Production, Approval and Review of Policies.		
Monitoring and Compliance:	The framework for monitoring and reviewing data quality will be through the annual Information Governance Toolkit submission and improvement plan and by the quarterly monitoring reports to the Information Governance Committee as described in paragraph 5.4. Regular monitoring will occur throughout the course of the year using the Data Quality Improvement Plans (DQIP) and processes we have with our Commissioners.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/ legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
1.01		*9/2010*	
2.0	*Review*	*11/2010*	
3.0	*Review*	*07/2013*	
3.1	*Review*	*08/2013*	*Minor change to introduction around scope of PBR and references to specific systems removed as content should be applicable to all systems.*
3.2	*Review*	*03/2014*	*Appendix 1 & 2 added back into the document. Deadline for entering data changed to 24 hours from three days. Reference to codes of conduct and Health & Social Care Records Policy. Director Name updated.*
4.0	*Review*	*12/2016*	*CCIO roles added to Duties and Responsibilities. Out of date links and contact details updated or removed.*
4.1	*Review*	*04/2017*	*Addition of DQIP process as a means of monitoring*
4.2	*Review*	*18/09/2018*	*Update references to Data Protection Act 2018 and General Data Protection Regulation.*
4.3	*Review*	*11/11/2019*	*Specific references to PBR removed. Updated procedures/monitoring inserted. Some moving of test to more suitable heading/section.*
4.4	*Review*	*21/11/2022*	

Appendix 4: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Data Quality Policy**
2. EIA Reviewer (name, job title, base and contact details): **Tony Greenlaw, Information Management Lead, Trust Headquarters**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service
To ensure data recorded in trust systems is fit for purpose
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: • Older people • Young people • Children • Early years	Low	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: • Sensory • Physical • Learning • Mental health (including cancer, HIV, multiple sclerosis)	Low	
Sex	Men/Male Women/Female	Low	
Marriage/Civil Partnership		Low	
Pregnancy/Maternity		Low	
Race	Colour Nationality Ethnic/national origins	Low	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	
Sexual Orientation	Lesbian Gay men Bisexual	Low	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision.	
None.	
EIA Reviewer: Tony Greenlaw	
Date completed: 21/11/2022	Signature: A Greenlaw