DATA QUALITY POLICY

The key messages the reader should note about this document are:

1. Accurate and timely clinical record keeping is the major factor that impacts on data quality.
2. Poor data quality directly impacts on the reporting of the Trust's activity, performance against mandated key performance indicators and clinical outcomes reporting.
3. If you collect, record, store, process or use data at work, you should be aware of this policy no matter what your role is in the organisation.
4. Any concerns you may have around record keeping and data quality should be escalated through your line management structure.
5. Data protection law requires the information we record to be adequate, accurate and, where appropriate, kept up to date. Data Quality is not just Trust policy or best practice, it's the law.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual or local risk assessment.

DOCUMENT SUMMARY SHEET
ALL sections of this form must be completed.

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Version	Amendment	Reason
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0.2	Revisions/formatting	Information Governance Group - comments
0.3	Further Revisions	Stakeholders for comment
0.4	Further Revisions	Comments from IM&T Governance Committee
1.0	Document ratified	
1.1	Updates and new Appendix D	Implications for data quality of the merger with York, Selby and North Yorkshire (February 2012)
1.2	Summary Sheet amended	To reflect Executive Team approval
2.0	Document ratified	
2.1	Updated to current template, improved logical flow, addition of DQ escalation process and assimilation of York services into document.	Regular review of document
3.0	Document ratified	
	Review date extended to March 2018	Document reviewed as fit for purpose, extensive review will be complete beginning of 2018.
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	system. Align to changes in external and internal governance structures.	Foundation Trust the Data Quality Policy has been updated to remove references to PARIS and PARIS processes.

CONTENTS

1. THE PROCEDURE

1.1 Flow chart of procedure (if relevant)

Flow chart not required for this policy

1.2 Description of Data Quality Policy

This policy is intended to:

- Confirm the Trust's commitment to a continual improvement in the quality of its data in order to support its business needs.
- Confirm the Trust's ongoing approach to ensuring data quality standards are adhered to.
- Inform staff working for, or on behalf of the Trust, of their duties with regards to data quality.

The data quality policy is an integral part of the Trust's approach to Information Governance and should be read in conjunction with other related information governance and clinical record keeping policies (*See appendix C*).

This policy primarily covers the data quality and clinical record keeping standards applicable to the collection, processing and exchange of data relating to clinical service delivery and therefore emphasis has been made in relation to trust information systems designed for these purposes. The principles set out within this policy should also be applied to other trust information systems.

The policy is aimed at all staff involved in the collection, recording, storage, processing, or use of service user-related data no matter what their role within the organisation. This includes promoting a culture of continual improvement, informing staff of their roles and responsibilities concerning the collection and input of good quality data and to establish these standards in training programmes.

1.3 Importance of Good Data Quality

Data quality is central to the Trust's ongoing ability to meets it's statutory, legal, financial and other contractual requirements.

The availability of complete, comprehensive, accurate and timely data is an essential component in the provision of high quality clinical services, risk management, compliance with external scrutiny requirements and in performance improvement against national and local targets, standards and contractual requirements.

Good data quality is essential to ensuring that, at all times, reliable information is available throughout the Trust to support clinical and/or managerial decisions. Poor clinical record keeping leading to poor data quality is not acceptable to the Trust due to the risks that could arise from the use of unreliable clinical and/or managerial information.

All Trusts are required to have good quality data that is compliant with national standards. The Trust is responsible for the quality of its data and is increasingly performance managed against standards and targets set by external bodies including NHS Improvement, NHS England, NHS Digital and the Care Quality Commission

Data has a wider audience than just within the originating organisation. All Trusts send a variety of mandated returns and data sets to other stakeholders, including to regional and national databases such as the Secondary Uses Service (SUS).

1.4 Aims and Requirements

The Trust aims to set the highest standards of clinical record keeping and data quality to support the safe delivery of care. The Trust will comply with national data standards, including the NHS digital, data and technology standards framework, and dataset requirements. The NHS Data Manual and Data Dictionary can be accessed via the NHS Digital website.

The Trust will also comply with the requirements of relevant new Information Standards Notices (ISNs) received from NHS Digital ensuring that the Trust produces comparable data for each of the data sets e.g. Mental Health Services Data Set (MHSDS). Datasets are important to Commissioners for contract monitoring and also increasingly to the NHS for obtaining statutory and other important information.

The Trust aims to make data quality implicit by ensuring that its systems are properly configured, the systems are user friendly and to encourage accurate input of data to minimise errors. Prevention of errors also includes ensuring local working instructions are in place, standard codes are used, appropriate fields are made mandatory and by enabling the means to collect and input data.

The functionality of systems must be configured and used to the fullest extent, following the business processes.

1.4.1 Information Systems

All clinical and administrative records must be input into approved Trust systems. The use of any IT system to record service user data, other than the ones listed in below, is to be avoided and has to be approved by the Information Governance Group.

The Trust's clinical systems will be configured, where possible, to ensure that the business processes are followed. In particular, that the system is configured to follow the patient pathway. The collection and input 'trigger points' will be identified and referenced in training materials. All changes to

the clinical systems will be will be quality controlled to assure standards concerning the accuracy of recording data.

Any codes within the clinical systems will comply with national and local standards. The Code Change Request procedure ensures that new codes requested are compliant to these standards and that there is compliance with any new Information Standards Notices (ISN). Any mappings required will be made in the Trust's Data Warehouse. Fields will be made mandatory where a data item must be collected in all circumstances. The need to make further fields mandatory is kept under review subject to the necessary criteria.

CareDirector – the Trust's primary clinical and patient administration system. Service user clinical information must be input and maintained in an accurate and timely manner

DATIX – the Trust's system for recording incidents, risks and complaints.

Electronic Prescribing & Medicines Administration (EPMA) – the Trust's e-prescribing system.

BigHand – electronic digital dictation software system used to dictate letters to GP's and other NHS services

Where standalone databases are to be used for research purposes approval must be sought via the Research and Development Department.

Aside from approved research projects (see above), staff must not use standalone systems to record service user data unless they have been agreed by the Information Governance Group.

Standalone systems are defined as any system that is used to record and/or retrieve service user data whether developed in-house or provided by third parties. The definition is not limited to applications developed in databases but covers any searchable front-end including spreadsheet and word-processing packages and manual systems.

1.4.2 Clinical Data

Clinical data covers anything that relates to interventions with service users, including appointments and contacts that are undertaken by medical/clinical staff working within or on behalf of the Trust, referrals to and discharges from clinical services.

The quality of this data remains the responsibility of the clinical member of staff even where the information is input on their behalf by administration staff.

All clinical data must be validated by clinical staff to ensure good quality electronic patient records. This will ensure that data used for the management and improvement of services and to meet performance and compliance requirements is also of good quality.

1.4.3 NHS Clinical Information Standards

The Trust will adhere to NHS Clinical Information Standards.

- The NHS standard for clinical data records is SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms). SNOMED CT is the published standard for all patient clinical information flows in the NHS.

- Diagnosis should be recorded using International Classification of Diseases (ICD10)

- Medicines and medical devices should be described using the Dictionary of Medicines and Devices (dm+d)

1.4.4 Demographic data

Demographic data covers all personal data belonging to the service user, including;

Items such as NHS Number and Date of Birth are essential so that service users are identified correctly.

Accurate and maintained addresses, telephone numbers, next of kin / family details and GP Practice registration are required for safe and appropriate communication.

It is against the law (The Equality Act (2010)) to discriminate against anyone because of 9 protected characteristics and it is a requirement of all public sector organisations to monitor and publish information to demonstrate their compliance with the public sector equality duty. The 9 protected characteristics are:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

All administration and clinical staff are responsible for checking demographic details with their service users at all appropriate attendances. Where changes are identified they should follow Trust procedures for ensuring that the change is recorded appropriately.

Where the basic demographic items are not recorded in the service users record the first member of staff to see the service user is responsible for establishing and recording these data items.

Key demographic data items are externally performance managed by NHS Improvement (the Trust regulator) and the Care Quality Commission (CQC) and in a number of submissions e.g. the Mental Health Services Dataset (MHSDS). Data quality is internally performance managed through the Trust's performance reports

It is vital that all demographic data is recorded accurately, completely and kept as up-to-date as possible.

The Trust will adhere to the NHS digital, data and technology standard that patient records for all health and care settings must use the NHS Number wherever possible by ensuring that the NHS number, as the unique service user identifier, will be implemented within all electronic systems and should also be included within manual/paper systems.

Staff should encourage service users to provide their NHS number. Where it is not already known the Summary Care Record (SCR) of the NHS Spine should be used by staff in order to confirm patient details and NHS number.

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.

1.4.5 Duplicate Records

Having a duplicate paper or electronically held record presents a high risk to service users and staff. Every effort should be made by staff to identify and eliminate duplicates. Rigorous application of the correct registration procedure for new service users on clinical systems is key to reducing duplicate electronic records. Where a duplicate has been identified a call should be raised with the IT service desk to request the electronic records be merged. Where a paper record is duplicated the guidance within the Health Records Policy should be followed.

1.5 Responsibilities for Data Quality

The recording of good data quality in line with clinical record keeping standards is a fundamental requirement for the effective, efficient and economical running of the Trust. As such, it should be considered as central to all future developments and it will be rigorously performance managed.

1.5.1 Trust Board and Quality Sub-Committee

Whilst the Chief Executive and Trust Board have overall accountability for clinical record keeping and data quality, responsibility for assurance and monitoring lies with the Quality Sub-Committee.

1.5.2 Information Governance Group (IGG)

This group's role is to ensure that identified issues with data quality and clinical record keeping are responded to with appropriate actions.

1.5.3 Lead Director

The Chief Financial Officer/Deputy Chief Executive, as Senior Information Risk Owner (SIRO) is the nominated lead for data quality. The Chief Financial Officer/Deputy Chief Executive is supported by the Chief Information Officer and Head of Performance Management and Informatics. These roles are responsible for:

- Ensuring corrective action is taken to improve data quality where this is required and
- The appropriate risk assessment mechanisms are in place in the Trust to identify where data quality improvement action may be required.
- Ensuring there is a framework of policies and procedures designed to promote data quality and that all systems are robust.

1.5.4 Clinical Leads and Heads of Operation

These roles are responsible for:

- Ensuring clinical record keeping and data quality are incorporated into performance meetings and clinical supervision.
- Addressing data quality issues within their area and the delivery of any data quality action plans.

1.5.5 Service and Team Managers

These roles are responsible for:

- Ensuring that all their staff are appropriately trained in data collection procedures, the Trust's clinical systems and the importance of good quality record keeping.
- Maintaining adherence to data quality policies and procedures and validation of clinical data locally.
- Monitoring performance against record keeping and data quality metrics, taking appropriate action within their services to rectify issues.
- Use processes such as clinical supervision and appraisal to ensure staff have the correct training and are meeting data collection standards.
- Ensuring teams do not set up local databases or manual data collections without approval from the Information Governance Group.

1.5.6 Clinical staff

These staff are responsible for:

- Complying with legislation, Trust policies, procedures and local working instructions.

- Ensuring timely, accurate and complete input of data from clinical notes/completed forms including patient demographic and activity data.
- Correcting errors or omissions in their data within 7 days of notification (including logging any error they are unable to correct with the IT service desk for correction).
- Monitoring own competencies and accessing appropriate clinical system training where necessary.
- Taking responsibility for data if the information is input on their behalf by administration staff.

1.5.7 Administrative staff

These staff are responsible for:

- Complying with legislation, Trust policies, procedures and local working instructions.
- Ensuring they have a clear mandate for recording clinical details on behalf of a clinician.
- Ensuring timely, accurate and complete input of data from clinical notes/completed forms.
- Checking the Summary Care Record (SCR) of the NHS Spine in order to confirm patient details and NHS number.
- Correcting errors or omissions in demographic data within 7 days of notification (including logging any error they are unable to correct with the IT service desk for correction).
- Monitoring, addressing if appropriate and escalating if required, any data quality issues.
- Monitoring own competencies and accessing appropriate clinical system training where necessary.

1.5.8 Health Informatics staff

These staff are responsible for:

- Providing a framework of policies and procedures designed to promote best practice in data quality (and information governance) and to ensure that all systems are robust.
- Configuring the Trust's clinical system to collect data according to agreed standards and undertaking maintenance of the system.
- Correcting errors on the system that users are unable to do for technical or other reasons.
- Liaison with the clinical system supplier to ensure national and local record keeping and data quality standards are maintained.
- Processing data from the Trust's information systems into the Data Warehouse accurately.
- Producing local and national datasets in line with agreed definitions and expected data quality standards (including Information Standards Notices (ISNs)).
- Managing validation processes with operational services to ensure any key performance indicators are produced using the best available data.

- Producing monitoring and clinical reports to support data quality, alerting individuals of errors and omissions and providing aggregated data against agreed metrics for record keeping and data quality.
- Running reports to compare the clinical system against the national NHS SPINE, correcting errors where possible (batch tracing).
- Working with operational teams to agree and report on data quality metrics to drive improvement.
- Putting in processes to validate and escalate data quality errors and omissions on a routine basis.
- Correcting minor errors in record keeping (data cleansing) where appropriate.
- Carrying out audits of data quality and record keeping.
- Providing reporting and assurance to the Quality Sub-Committee.
- Providing reporting and assurance to the Information Governance Group. The IG Group has responsibility for approval of this policy.
- Ensuring that clinical coding is accurate, complete and timely using the standards set nationally and locally. This will include using auditable source documents such as the electronic patient record and liaison with clinical staff for resolving issues.
- Providing expertise to the various digital systems' groups to allow decision making on developments and changes to the clinical system to support the data quality agenda.

1.5.9 Clinical Coder

These staff are responsible for

- Clinical coding on CareDirector will be carried out for all inpatient Finished Consultant Episodes (FCEs) according to the local working instructions for Clinical Coding from auditable source documents.
- Supporting the annual audit to be carried out by a nationally accredited external clinical coding auditor.

1.6 The Principles of Good Data Quality

Good quality data means data that is:

- Complete - No relevant data is missing.
- Accurate – Data is correct at the time it is collected and codes are selected which are valid in the context they are used.
- Up To Date – Most data is valid at a point in time and needs to be reviewed periodically; data needs to be entered into systems promptly.
- Fit For Purpose – The right data for the purpose required and collected to common standards.
- Relates to the Correct Person – It is crucial that a person has a single record identified to the right person:
    - Free from duplication
    - Free from fragmentation
    - Free from confusion

Information Governance (IG) is a legal and ethical framework which governs the collection, use, storage, retention and disposal of information. Information Governance provides the Trust with a consistent way of dealing with all the requirements of information handling. It has a much wider focus than pure data quality, including Data Protection, Records Management, and Confidentiality, and provides a framework to bring together all the requirements, standards and best practice that apply to the handling of personal information. Adopting the framework offered by Information Governance will ensure that the Trust and its staff are using and handling data in compliance with legislation and with current guidance.

1.6.1 The General Data Protection Regulation (GDPR) (from May 2018)

The GDPR states:

- Information should be adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed.
- Information should be accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay.

Although there are many aspects to good quality data, the general principles are that data should have the following attributes:-

Validity

All data items held on the Trust computer systems must be valid. Where codes are used, these will comply with national standards; locally defined code sets will map to national values. Wherever possible, computer systems will be programmed to error-trap invalid entries.

Completeness

All internally agreed data items within a data set must be completed. Systems will be programmed to force the input of mandated fields for national requirements. Use of default codes will only be used where appropriate and not as a substitute for real data. If it is necessary to bypass a data item in order to admit or treat a service user, the missing data must be reported for immediate follow up.

Reliability

Data items must be reliable and internally consistent. For service users with multiple episodes, recorded dates must be consistent and where multiple referrals or episodes exist, interventions must be linked correctly. Clinical coding must be consistent for ages and sex.

Coverage

Data will reflect all the clinical work carried out by Trust staff. Admissions, discharges, transfers, activity, attendances, must be all recorded. Correct

procedures are essential to ensure complete data capture. Spot checks, exception reports and audits should be used to identify missing data.

Accuracy

Data recorded in case notes and on computer systems must accurately reflect each other and the care and treatment provided to the service user.

All reference tables, such as GPs and postcodes, will be updated regularly. Procedures will be in place to ensure that updates occur within reasonable timescales of publication.

Every opportunity should be taken to check demographic details with the service users themselves. Inaccurate demographics may result in important letters being mislaid, or the incorrect identification of individuals and, ultimately, poor quality information.

Timeliness

The recording of information should be entered into Trust clinical systems in real time but where this is not possible, within a maximum of 24 hours of occurring.

The recording of timely data is essential to the safe and effective care and treatment of the service user. Up to date inputting of contacts and interventions means that the latest known information about the service user will be available to all other care professionals, even if they do not have access to the paper notes.

All data must be recorded within specified deadlines; best practice dictates that data entry should take place at, or as near as possible to, the event being recorded. This will ensure that up to date data can be included in national, local and internal reports.

Data quality issues should be corrected / resolved within 7 days of notification / escalation.

1.7 Measurement, Monitoring and Training

The Trust's clinical record keeping and data quality framework outlines the governance and monitoring for this agenda (see appendix A).

Regular reviews of the quality of the Trust's clinical data will take place at the;

- Operational Delivery Group (ODG). Where data quality standards are identified as a risk, these will be reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation and added to the Trust's risk register.
- Through the Quality, Delivery and Performance (QDaP) process, including at service line QDAP groups.
- Where poor clinical record keeping has been identified at an individual level, this should be discussed as part of clinical supervision.

1.7.1 Identifying and Correcting Errors and Omissions

The responsibility and ownership of data rests with the system user who must ensure that any errors are corrected promptly at source. Where validation reports are available from systems for use by clinical, managerial and informatics staff, these should be used to check for inaccurate, incomplete or untimely data.

Clinicians play an important role in the validation and verification of data. This is achieved by, for example, confirming caseload lists and activity levels through reporting which may also be used for Consultant appraisals.

Accordingly team managers will continue to build partnerships with clinicians in order to assure that all data is collected and input into the appropriate Trust system. Clinicians/care-coordinators must regularly check their caseloads on a weekly basis reporting any discrepancies with immediate effect to their team manager for investigation.

Informatics will develop dashboards and other reporting to support processes to prevent and identify incorrect or missing data. Where functionality allows, this will be developed within systems and using live data. Quantified monitoring of identified data quality issues will be supported by summary management / performance information available through the B.I system.

The NHS Spine should be used to confirm service user details including NHS Number, GP Practice registration, date of birth, date of death and addresses. Accessing data from the NHS Spine may be done through individual user access via a smartcard, batch tracing of multiple records against using the Patient Demographic Service (PDS) or Spine enabled clinical systems.

The appropriate department or individual/service must investigate queries, gaps in data items, and anomalies raised as a result of report production. Errors and omissions must be corrected within agreed timescales (7 days from notification). In cases where the system does not allow a user to correct or amend an error these should be logged with the IT Service desk.

Failure of staff members to comply with the Trust's Data Quality Policy and Procedures may result in the individual being put through the Trust's Disciplinary Process. This may become evident from monitoring of error reports. Training needs will also be established through this process if the same person or Team is making persistent errors and escalated in line with the clinical record keeping and data quality framework.

External data quality reports, such as those produced by the Secondary Uses Service, NHS Improvement, NHS Digital, the Care Quality Commission & the Department of Health, will be checked by Health Informatics staff and any issues addressed before the next return deadline.

1.7.2 Scrutiny

Data quality will be subject to both internal and external scrutiny.

Internally:

Data quality targets & standards will be defined through the Quality, Delivery and Performance (QDaP) process or according to national requirement / specification and will ensure that key data quality Performance Indicators (KPIs) are included within the hierarchy of the Trust performance reports.

Internal monitoring reports will be used to inform management, improve processes and documentation, and identify training needs. Internal audits will be carried out on systems, processes and data quality to ensure continued compliance with Trust standards.

Regular updates will be made to Information Governance Group on identified data quality issues, including detailing the actions required to manage the data quality issue and the progress of these actions.

Existing communication routes such as Trust-wide bulletins, service line QDAP meetings and email will be used to raise and escalate data quality issues and resolutions.

Externally:

Where external agencies receive or have access to Trust information and produce data quality reports and indicators, the Trust will aim to meet the required levels of accuracy and completeness on all items. The Data Quality Maturity Index (DQMI) is used within the NHS Oversight Framework, Model Hospital and CQC Well-led domain performance frameworks. NHS Digital publications of DQMI will be routinely reviewed and incorporated into internal monitoring reports.

A number of external regulatory bodies (e.g. NHS Improvement; the Care Quality Commission) rely on information based on good quality data and carry out regular audits of data quality.

Designated staff will address issues highlighted by reports or indicators that demonstrate poor quality data. Recommendations made as a result of data quality audits will be acted upon within agreed timescales.

1.7.3 Training

Staff will be provided with training appropriate to their needs on how to use the appropriate Trust system and record information by using coding structures correctly. This will include attendance on the Trust's Induction Course and completion of the e-Learning Data Security Awareness. Any changes to information requirements and/or systems may require further

update training where necessary and this will be provided. This training will also include data quality aspects as well as how to use the system and also refer to local procedures.

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 in the first place. To achieve this, on the job training and induction programmes for all new staff must include training in the use of computer systems that is appropriate to their role. Access to systems will not be granted until appropriate training has been completed. Existing staff must have access to ongoing training to keep them up-to-date with new processes and changes to data definitions.

Training must be backed up by regularly reviewed procedures. These should be properly documented and accessible to all appropriate staff. Staff should be made aware of where these are stored and how to access them. Trust-wide communications will be used to support sharing tips and advice on clinical record keeping and data quality.

Appraisals will ensure that training and development needs for all staff using computer systems are identified and training accessed.

1.7.4 Dissemination and Implementation

The approved policy will be made available for all staff on the Trust's StaffNet. Information about the policy availability will be disseminated via the Trust's news bulletin. The Senior Information Manager will oversee the implementation of the policy supported by the Head of Performance Management and Informatics and the Operational Delivery Group (ODG).

The policy will be reviewed every 3 years or earlier should there be national or local changes which impact on its content.

2 Appendices

A: The Clinical Record Keeping and Data Quality Framework

IMPROVING CLINICAL RECORD KEEPING & DATA QUALITY

"Data does not need to be 100% accurate at all times. However, it does need to be of a consistently high enough standard to meet the user's needs, so that it is fit for purpose and can be used with an acceptable degree of confidence[1]"

FRAMEWORK

What does clinical record keeping and data quality mean?

Whilst clinical record keeping and data quality are intrinsically linked they do refer to different things.

The clinical record applies to all information written and collated about a service user either electronically within one of the Trust's clinical systems or on a paper health record. High quality clinical record keeping involves ensuring that all contacts with a service user and the content of the contact are recorded and all information about their health including any co-morbidities or allergies is clear and easily accessible to anyone using that record. In short, good clinical record keeping refers to the content and quality of any record for one particular service user.

Data quality usually refers to the quality of aggregated outputs from many clinical records and the impact this has on analysing the data. For example, a detailed narrative within a clinical record explaining all about the service user and the treatment they have received may be a good clinical record but unless it is input into structured fields that can be aggregated with other records and analysed, the data quality is poor.

Data quality is also impacted by the timeliness of input into the individual clinical record. If the information is not recorded until weeks after the contact with a service user has occurred it is likely that it will not be included in aggregated data that flows to commissioners and other external bodies such as NHS England and NHS Digital.

Poor clinical record keeping directly impacts on patient care and safety but also data quality. Poor data quality directly impacts on the reporting of the Trust's activity, performance against mandated key performance indicators and clinical outcomes reporting. This will then impact on the Trust's reputation (both with service user and commissioners) and income.

Why do we need a framework?

"NHS Digital recommends the use of a supportive Performance Evidence Framework designed to help data providers to improve their level of data quality by enhancing their own local processes[2]"

The aspiration of real time, complete and accurate recording of information in a structured format that meets both clinical and analytical needs is not an easy task and we are not yet there as an organisation. Providing a framework that sets out how the measuring and improvement of clinical record keeping and data quality will be managed and supported is an important step in recognising the size of the task and facing it together.

Hurdles to overcome:

Externally, the Trust is required to submit monthly data to NHS Digital for the mental health minimum dataset which is analysed and published via a range of performance and activity measures. Organisations submit each month's data a month after the activity occurred and are able to refresh this a month later. Following this second submission, no further updates are possible so any quarterly (or later) data cleansing and validation or late input will never be reflected in the Trust's performance. For example, a discharge entered after the refreshed cut off point will always remain open in NHS Digital's data impacting on any length of stay analysis.

Currently, many key performance indicators (e.g. for NHS Improvement) are reported at an aggregated level on a quarterly basis for each indicator. In the run-up to each quarterly submission, significant validation work is carried out to ensure the most accurate position of performance is reflected. However, the direction of travel for waiting times and other targets is likely to be via the monthly submissions to NHS Digital instead. This means that validation needs to be on a monthly, or ideally on a real time, basis; this is not embedded into current practice.

In order for accurate performance and outcomes data to be analysed, the information needs to be entered in a structured way onto the Trust's clinical systems. This can feel like an extra burden for administrative and clinical staff when compared to free text narrative either electronically or on paper.

Staff can feel disassociated from the mandated key performance and outcome measures and frustrated by their definitions. Routine monitoring of these measures is often done at a managerial level and is not part of normal business for many clinical and administrative staff as they are not seen as directly related to individual care of a service user and viewed as low priority. It is generally difficult to engage staff in the data quality agenda as it is viewed as a "dry" subject removed from day to day work. Some national indicators are not well-defined and open to interpretation or have not kept up with changes in practice which can undermine their relevance to staff and make reporting difficult.

If we are to move towards more outcome based reporting to evidence performance; complete, timely and accurate clinical record keeping in an agreed structured format with clinical "buy-in" will be critical.

How will it work in practice?

"Quality is never an accident; it is always the result of intelligent effort[3]"

Whilst the Chief Executive and Trust Board have overall accountability for clinical record keeping and data quality, responsibility for assurance and monitoring lies with the Quality

Sub-Committee. Identified issues with data quality and clinical record keeping are responded to with appropriate actions and reported at Information Governance Group.

Data quality targets & standards will be defined through the Quality, Delivery and Performance (QDaP) process or according to national requirement / specification and will ensure that key data quality Performance Indicators (KPIs) are included within the hierarchy of the Trust performance reports.

QDaP will also provide the vehicle for raising any concerns around clinical record-keeping and data quality, with operational staff members ensuring that any key messages are taken back into clinical services for dissemination. Repeated or prolonged issues will be escalated through Operational Delivery Group (ODG) and Quality Committee to Trust Board if/when required.

What support is on offer?

> "Our staff will have access to information that lets them know how they are doing and the skills to understand it and the ownership to improve where necessary[4]"

Oversight for data quality lies with the Head of Performance Management and Informatics. Members of the Health Informatics teams will promote good record-keeping and improvements in data quality through their interactions with clinical and administrative staff and in developing reports. There will representation from Health Informatics at QDaP meetings where record keeping issues and impacts of poor data quality can be raised.

As submission dates for key performance indicators approach (e.g. for NHS Improvement's Single Oversight Framework), the Health Informatics teams will send out emails to key contacts in clinical services highlighting records that require validation.

Health Informatics staff will provide expertise to the various digital systems' groups to assist decision making on developments and changes to the clinical system to support the data quality agenda. They will work with the clinical system trainers to provide quick guides for teams to refer to for record keeping hotspots and provide support and assistance to teams that are struggling to implement robust practices.

What are our expectations of staff?

> "It is important that staff own the data on their activity, and understand how that translates to the delivery of high quality patient care and corporate performance within the organisation[5]"

All administrative and clinical staff inputting into a service user's record should ensure that their input is complete, accurate, timely and valid. Trust standards require information should be entered into Trust clinical systems in real time but where this is not possible, within a maximum of 24 hours of occurring. This serves the dual purpose of minimising clinical risk and ensuring high standards of data quality.

If requested to make amendments to incomplete or inaccurate data individuals should ensure that these are carried out within 7 days of the request. Any delays in resolution or requests for further information or support should be addressed to the IT Service Desk.

How will we know progress is being made?

"Internal monitoring reports will be used to inform management, improve processes and documentation, and identify training needs. Internal audits will be carried out on systems, processes and data quality to ensure continued compliance with Trust standards"

Data quality targets & standards will be defined through the QDaP process or according to national requirement / specification. Data quality KPIs are included within the hierarchy of the Trust performance reports.

Annual internal data quality audits will be undertaken to provide additional assurance.

Regular updates will be made to Information Governance Group on identified data quality issues, including detailing the actions required to manage the data quality issue and the progress of these actions.

Contacts and References:

For questions or queries in relation to clinical record keeping and data quality, please contact either:

Nikki Cooper, Head of Performance Management and Informatics, 07970 614753

Ian Burgess, Senior Information Manager

[1] *NHS Scotland: Practice Team Information: Data Quality Model, March 2012*

[2] *NHS Digital: Data Quality Maturity Index (specification) published 9 May 2017*

[3] *John Ruskin, Theologian, Art Critic and Social Commentator (1819-1900)*

[4] *Leeds and York Partnership NHS Foundation Trust Quality Strategic Plan, 2018 – 2021*

[5] *"Mind the Gap" – Our Governance, Accountability, Assurance and Performance Framework, December 2017*

[6] *LYPFT Data Quality Policy IG-0006*

B: Examples of How Data Quality Can Impact Upon Care

The following are fictitious examples but which illustrate problems which could arise.

Example 1

Mrs Smith was referred suffering from depression to a consultant by her GP. An outpatient appointment was arranged and she came to the clinic. Whilst in the waiting area she decided that she could not face seeing the consultant and so left.

At the end of the clinic the receptionist was unable to record the outcome of the outpatient appointment because Mrs Smith had not returned to the desk. The consultant had left. It was not picked up by anybody that Mrs Smith had not received treatment and the GP was unaware that she had not attended the appointment. This only came to light when Mrs Smith made another appointment to see her GP.

This would have been prevented if the consultant had informed the receptionist that he/she had not seen the patient or if the receptionist had contacted the consultant the next day to check this.

Example 2

Mr Jones was referred to the organisation as his psychiatric condition had seriously deteriorated. Crisis Resolution found Mr Jones' CPA details on the clinical information system. This indicated that his Care Co-ordinator was Richard Brown. Crisis Resolution tried to contact Richard Brown to discuss Mr Jones condition however following a CPA review two weeks ago another CPN, John Taylor, had taken over as Mr Jones Care Co-ordinator. This change had not yet been entered on the clinical information system resulting in a delay in contacting the correct care coordinator and arranging appropriate treatment for Mr Jones.

This would have been prevented if the clinical information system had been updated promptly for the change.

Example 3

The Clinical Commissioning Group (CCG) is undertaking a review of how it commissions community-based mental health services. It is looking to target resources on areas of the city where there are more mental health problems. It has asked for data on spending on community mental health services in each part of the city and the number of service users in those areas. This data showed that CMHT C had the least resource in relation the number of clients that it is treating. The CCG therefore agreed to provide extra resources to be targeted in CMHT C. However several staff in CMHT D have not been inputting activity into the clinical information system to record patient contacts because they find it an additional burden on their much pressured time. If this data had been available then it would have highlighted

that the CMHT D had the least resource in relation to its workload and it would have been able to recruit an additional member of staff. Ensuring that complete activity information was recorded would have enabled a better decision to be made about the allocation of resources.

Example 4

Mr Singh was discharged from hospital following a few days inpatient psychiatric treatment. A discharge letter was sent to his GP. However Mr Singh had moved house and so changed GP since he had last been in contact with Trust services.

As no checks had been made as to whether the GP had changed the letter was sent to the old GP. The letter contained details of his condition during his inpatient stay and medication that he been prescribed. This resulted in him not receiving the medication and timely follow-up treatment from the GP.

Asking Mr Singh if his GP had changed and checking Mr Singh's GP (using the NHS Spine) would have enabled the letter to be sent to the correct GP.

C: Glossary of Terms:

The following definitions are of relevance to this document:

Batch Tracing – the process by which multiple records can be submitted electronically to verify patient demographic records against information held on the NHS Patient Demographics Service (PDS).

Clinician – this term is used in the document to include all health care professionals.

Data - the term 'data' is often used to mean the raw information which is collected e.g. the GP and ethnicity of an individual service user. The distinction is made with 'information' which is of a statistical nature useful for a particular purpose e.g. the proportion of service users from an ethnic minority background.

Data Quality Assurance – is the process by which data is verified as complete, accurate, up to date, fit for purpose, relates to the correct person and is free from duplication and fragmentation.

Data Security and Protection Toolkit – has been made available by NHS Digital to assist organisations to achieve the aims of Information Governance. It is an assessment tool that is also used to improve the Trust's overall compliance with policy.

Electronic Patient Record (EPR) – is a patient record in an electronic format.

Information Governance is a term used to describe good practice in the management of information by ensuring necessary safeguards and appropriate use of personal and patient information. It includes data quality, but also data protection, records management, confidentiality and IT systems security.

Information Standards Notice (ISN) - formal notification of an information standard. It provides a summary of the information standard, with implementation dates, and links through to the following components of an information standard.

NHS Patient Demographic Service (PDS) or NHS Spine – is the national NHS database for all patients registered with the NHS in England and Wales which is regarded as the definitive source of information concerning a patient record contained in the **Summary Care Record (SCR).** The PDS is regularly updated from GP patient notifications and contains demographics, current GP details and also indicates deceased patients. It is also used to verify electronic patient records by batch tracing.

Service user (and carer) - this document uses the term service user as a synonym for **'patient'** and **'client'**. A service user is someone who receives care from Trust services; they can also be a carer. They will have a record in a trust clinical information system. Services include: Inpatients, Outpatients and Community.

Staffnet – The Leeds and York Partnership NHS Foundation Trust's intranet.

SUS (Secondary Uses Service) - SUS is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. SUS is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

PART B

3 IDENTIFICATION OF STAKEHOLDERS

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

Stakeholder	Level of involvement
Head of Performance Management and Informatics	Development
Senior Information Manager	Development
Information Manager	Development
Information Governance Group	Consultation and Approval
Policies and Procedures Group	Ratification

4 REFERENCES, EVIDENCE BASE

Records Management Code of Practice for Health and Social Care 2016

NHS Digital Data Quality Maturity Index

NHS Clinical Information Standards

NHS Data Coordination Board: Information Standards Notices

NHS Digital Data Security and Protection Toolkit

5 ASSOCIATED DOCUMENTATION (if relevant)

C-0060: Being Open and Duty of Candour Policy

C-0015 The Identification of People using the Service of Leeds and York Partnership NHS Foundation Trust

C-0029: Trust-Wide Care Programme Approach Policy

IG-0001: Information Governance Policy

IG-0002: Health Records Policy

IG-0003: Confidentiality Code of Conduct

Terms of Reference: Operational Delivery Group

Terms of Reference: Information Governance Group

6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)

NHS clinical information standards (https://digital.nhs.uk/about-nhs-digital/our-work/nhs-digital-data-and-technology-standards/clinical-information-standards)

Data Quality Maturity Index (DQMI) (https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality)

Data quality issues should be corrected/resolved within 7 days of notification / escalation.

Information should be entered into Trust clinical systems in real time but where this is not possible, within a maximum of 24 hours of occurring

7. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified any potential negative impacts for any of the nine protected groups.

Print name: N Cooper

Job title: Head of Performance Management and Informatics

Date:

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; diversity.lypft@nhs.net.

*delete as appropriate

CHECKLIST

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers

	Title of document being newly created / reviewed:	Yes / No/
1.	**Title**	
	Is the title clear and unambiguous?	*Yes*
	Is the procedural document in the correct format and style?	*Yes*
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	*Yes*
3.	**Content**	
	Is the Purpose of the document clear?	*Yes*
5.	**Approval**	
	Does the document identify which committee/group will approve it?	*Yes*
6.	**Equality Impact Assessment**	
	Has the declaration been completed?	*Yes*
7.	**Review Date**	
	Is the review date identified?	*Yes*
	Is the frequency of review identified and acceptable?	*Yes*
8.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	*Yes*

Name of the Chair of the Committee / Group approving			
If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified.			
Name	*Carl Starbuck*	Date	*16/12/2020*
Name of the chair of the Group/Committee ratifying			
If you are assured that the group or committee approving this procedural document have fulfilled its obligation please sign and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet.			
Name	*Cath Hill*	Date	*21/01/2021*