Worcestershire Health and Care NHS
NHS Trust

Data Quality Policy

DATA QUALITY POLICY

Document Type	Corporate
Unique Identifier	QG001
Document Purpose	This policy defines the appropriate data quality responsibilities in the Trust.
Document Author	Della Lewis, Head of Quality Governance
Target Audience	All Trust Staff
Responsible Group	Data Quality Improvement Group
Date Ratified	27th January 2016
Expiry Date	27th January 2019

Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
V1	8/9/15	Data Quality Group	Clearer definitions and formatting changes
V2	23/11/2015	Data Quality Group	
		Director of Quality and Executive Nurse	
		Director of Operations	
		Deputy Director of Nursing	
		Company Secretary	
		Head of Contracts and Information	
		Head of Finance (Systems and Reporting)	
		Performance and Information Manager	
		Head of Information Governance	
		Director of Finance	
		Quality Governance Information Lead	
		Compliance Manager	
		Deputy Head of Quality Governance	
		Patient Relations Lead	
		Patient Experience Lead	
		Patient Safety Manager	
		Patient Safety Information Officer	
		Quality and Safety Team Projects Lead	
		Audit, Research and Clinical Effectiveness Manager	
		Risk and Security Manager	

		Head of Corporate Nursing & Education	
		Associate Director of Workforce – HR Operations	
		Workforce Transformation Manager	
		Planning and Programme Management Lead	
		Training Compliance Manager & OLM Lead	

Accessibility

Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting.

Please refer to the intranet page: http://nww.hacw.nhs.uk/a-z/services/translation-services/ for full details of the service, how to book and associated costs.

Training and Development

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

1. Introduction

- This policy defines the standards for data quality in the Trust and links directly with the Trust's Performance Management Framework, Patient Administration Process Policy and Information Governance Policy.
- Reliable information is a fundamental requirement for the effective delivery of health care services. The availability of complete, accurate and timely data is important in supporting the Trust's vision, strategic objectives and quality aims.
- Trust Board, staff and clinical teams, patients, the public and our commissioners need to be assured of the quality of the information used to assess the performance of Trust services.
- Consistency and compliance with national standards is essential as the Trust is measured and judged on the data submitted to national databases.

2. Purpose

This policy defines the appropriate data quality responsibilities for everyone in the Trust. It shapes a common understanding of what good data quality looks like so that:

- Trust Board is able to rely on the production of appropriate and timely information
- the information we produce is seen as an invaluable tool supporting clinical care
- clinical teams and non-patient facing staff recognise their vested interest in ensuring that the information collected is of the highest standard
- patients, carers, the public, our commissioners and regulators understand and trust the information we report on.

This policy is purely focussed on assessing and judging of the quality of data, as opposed to assessing and judging actual performance.

3. Definition

Monitor's Well-led Framework, (www.gov.uk/government/uploads/system/Well-led_framework) sets out the following dimensions for good data quality so that the information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant:

- accuracy: data is recorded correctly and is in line with the methodology for calculation
- validity: data has been produced in compliance with relevant requirements
- reliability: data has been collected using a stable process in a consistent manner over a period of time
- timeliness: data is captured as close to the associated event as possible and is available for use within a reasonable time period
- relevance: data is used to generate indicators that meet eligibility requirements as defined by guidance.

This policy supports the Monitor definition and standards set out within the Well-led Framework.

4. Scope

This policy applies to all staff working within the Trust.

All Information Systems within the Trust (both electronic and paper based) fall within the scope of the policy. It applies to all data that is collected and published in Trust performance reports, both within the Trust and for external compliance. Trust information systems include Electronic Patient Records, Finance, Risk (Ulysses), Training, Staffing and, Human Resources databases (e.g. ESR).

This policy links very closely with the Trust's Performance Management Framework and the Patient Administration Process Policy.

The following acts, codes of practice and standards place a statutory duty on the Trust to ensure the completeness and accuracy of data:

- Data Protection Act 1998.
- Freedom of Information Act 2000.
- Public Records Act 1958 and 1967
- Access to Health Records Act 1990
- Confidentiality: NHS Code of Practice
- Records Management: NHS Code of Practice
- Caldicott Review of Patient Identifiable Information 1997
- NHS Litigation Authority Risk Management Standards 2003
- NHS Information Authority Information Governance Toolkit.

5. Responsibilities and Duties

The Chief Executive has the ultimate responsibility for data quality in the Trust.

The Associate Director of Information and Performance together with the Head of Quality Governance are responsible for overseeing the management of data quality. The Trust's Data Quality Improvement Group (DQIG), chaired by the aforementioned leads, reports to the Audit Committee and steers the delivery of the data quality improvement programme in the Trust. The Terms of Reference for this Group are attached in appendix one.

The Head of Information Governance is responsible for overseeing compliance with Information Governance legislation such as the Data Protection Act and The Freedom of Information Act.

Managers are responsible for monitoring the quality of data relating to their teams or services by means of the system-generated reports available to them. Each Manager should measure and seek to improve the completeness and validity of key data items on their system.

All staff are personally responsible for the quality of data entered by themselves, or on their behalf, on the Trust's systems. Individual staff are responsible for entering data in a timely, accurate and secure way and ensuring errors are dealt with in a timely manner and resolved or escalated where appropriate.

Each individual has a duty to be able to understand the information systems that are relevant to their post, how to use them effectively and must maintain their own knowledge and competency. If individuals have any specific requirements then these should be discussed with their line manager in order to ensure that they receive appropriate training and support.

Managers are responsible for ensuring staff are aware of the importance of good quality patient data, that staff in their teams have access to the correct systems, and have sufficient training and understanding in the use of systems used for recording data.

6. Training/Competencies

Staff must be able to evidence in the use of any of the information recording systems relevant to their work. As new systems are introduced, the project team responsible for the introduction must ensure there is adequate provision for the training of all staff. All project teams related to new information systems in the Trust must ensure a senior member of the Training and Development Team is involved in the mobilisation of the project from the outset.

7. Policy Standards

Validity - All data items recorded for the Trust Board and its committees are agreed through the Trust's Performance Management Framework.

Completeness – All mandatory data items will be completed to ensure that a full data set is captured for the activity being recorded. Wherever possible, computer systems will be programmed to only accept complete entries.

Consistency – Consistent information will be recorded. Where codes are used, these will comply with national standards or will map to national values. Wherever possible, computer systems will be programmed to only accept valid entries.

Accuracy – Data that is collected and recorded will accurately reflect the activity that it was intended to capture.

Accessible – Reports setting out data and information will be user-friendly in order that the reader can understand what the data is telling him/her.

Timeliness – Data will be recorded to the established deadline, which will enable that data to be included in the Trust's local and national reporting deadlines. All activity data will be recorded at the time, or as close to the time as possible that that event occurred.

8. Selection of Performance Metrics and Indicators

The Trust's Performance Management Framework (section 7.2) sets out the drivers that direct the range of metrics that are reported on in the Trust.

9. Data Quality in Key Performance Indicators

From April 2016, all Key Performance Indicators (KPIs) listed in the Trust's Performance Management Framework, will have a written data quality checklist (appendix two).

This means that each KPI reported through to the Trust's committees and Trust Board will have:

- The name of the KPI
- A definition of the KPI
- The source of the data / information system from which the KPI is derived
- Information regarding how the KPI is calculated
- The services from the which the data is collected

10. Implementation

The DQIG will oversee implementation of this policy. The DQIG has an agreed work plan which is revised at each meeting. Progress on the implementation of Data Quality Policy and the DQIG work plan is reported through to the Trust's Audit Committee.

11. Monitoring

Data quality is subject to control processes within the Trust (e.g. internal audit and clinical audit) and is also subject to external scrutiny. External audit of the Trust's quality account takes place each year and includes substantive testing of sample quality indicators.

The Trust's Information Team will report to the Data Quality Improvement Group on the progress from the Trusts data quality audits and data items, which have been identified as causing concern (e.g. NHS numbers, ethnic group, inpatient coding completeness). Improvement action plans for areas identified as causing concern will be agreed at DQIG and will in turn be reported to the Audit Committee, with escalation to Trust Board where necessary.

The Trust undertakes or commissions an annual assessment and audit of its compliance with Information Governance legal requirements by means of the Department of Health's Information Governance Toolkit.

The DQIG will review the Trust's data quality improvement action plan at each meeting. DQIG will also monitor the results of data quality audits and associated action plans and provide associated reports to the Audit Committee

12. Associated Documentation

This policy links very closely with the Trust's:

- Performance Management Framework
- Patient Administration Process Policy.
- Clinical record keeping policy
- Information Governance policies

Appendix 1

DQIG TOR to be added to final version

Appendix 2

Worcestershire Health and Care NHS Trust Data Quality Checklist

This must be completed for all Class One and Class Two Metrics.

Measure name:
Definition of the measure (what is being measured?)
Is this a Class One or Class Two Metric?
Who has requested the measure (e.g. TDA, commissioners, Trust Board)?
What is the data source, i.e. which system will provide the data for this measure? (e.g. Carenotes, Ulysses, ESR, manual audit)
How is the measure calculated?
Which services/SDUs are included in the measure?
How often is the data entered at source (i.e. do staff enter data on a daily basis, once a month, once a year)
How often will the measure be reported?
In which dashboards or reports will the measure appear?
Where will decisions be made based on results?

Terms of Reference – Data Quality Improvement Group

Committee Name	DATA QUALITY IMPROVEMENT GROUP
Date Agreed	March 2014
Review Date	Annually unless circumstances dictate that an earlier review is required
Updated	***Reviewed January 2016***
Purpose	**The Data Quality Improvement Group (DQIG) is a formally constituted sub-committee of the Audit Committee. The purpose of the Group is to:** ▪ Identify barriers and obstacles to the use of data and information by the Trust, and to implement actions to remove those barriers; ▪ Provide assurance that the systems and processes to support data recording across the Trust are robust and that the information contained within the reports presented to the Board, Committees, clinical teams and other partners, such as commissioners, is accurate; ▪ Address any issues regarding data quality that arise from external scrutiny of Trust information (e.g. Care Quality Commission, Trust Development Authority, commissioners and other stakeholders) ▪ Ensure the implementation of the recommendations from annual Internal Audit Report into Data Quality and any other external assessments of data quality that may take place; ▪ Identify specific areas of concern with regard to data quality and determine the approach to rectify these shortfalls; ▪ Ensure consistency of data collection and reporting between the SDUs; ▪ Identify the nature of information, both in terms of the style of presentation, the mode and frequency of delivery, that is required by front-line teams to support more effective and efficient service delivery. ▪ Develop and deliver an annual workplan that will be formally approved by the Audit Committee.
Membership	**The membership of the Group will consist of:** ▪ Mick Mather – Associate Director of Contracting Information and Performance (Chair) ▪ Della Lewis – Head of Quality Governance (Vice Chair) ▪ Sue Kite – Senior Information Analyst ▪ Mel Roberts – Locality Lead, Community Care SDU

	▪ Ursula Hare - Interim Community Services Manager, Community Care North SDU ▪ Karen Ingram, Clinical Lead, Adult Mental Health SDU ▪ Katherine Leach – Quality Lead, Children, Young People and Families, Sexual Health and Dentistry ▪ Steve Sidwell – Performance and Information Manager **In the event that members of the Group are unable to attend, deputies must attend in their place and must be furnace with adequate knowledge to be able to contribute effectively to the meeting.**
Chairman	**Associate Director of Contracting, Information and Performance**
Quorum	**The following members need to attend for the Group to be quorate:** • **Associate Director of Contracting Information and Performance or Head of Quality Governance** • **2 representatives from the SDUs** • **1 representative from Corporate departments**
Frequency of Meetings	The Group will meet on a bi-monthly basis.
Agenda	**The agenda and relevant papers will be distributed by the Associate Director of Contracting, Information and Performance. A record of action points will be taken and distributed no later than ten days following the meeting.**
Reporting Arrangements	**A report will be submitted to the next Audit Committee in the month following the DQIG meeting.** **The Chairman of the group shall draw to the attention of the Committee in a timely fashion any issues that:** ▪ **require disclosure to the full Board** ▪ **require urgent executive action** ▪ **are of strategic importance**

Equality Analysis

Worcestershire Health and Care NHS
NHS Trust

Title of Policy/Function (Function Includes: Services; Projects; Strategy; Processes; Systems; Practices; Procedures; Protocols; Guidelines; Care Pathways etc..)	New	Existing/Revised
Data Quality Policy	X	

Short description of Policy/Function (aims and objectives, is the policy/function aimed at a particular group if so what is the intended benefit):

This policy defines the appropriate data quality responsibilities for everyone in the Trust. It shapes a common understanding of what good data quality looks like so that:

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Name of Lead/Author(s)	Job Title	Contact details
Della Lewis	Head of Quality Governance	Della.lewis1@nhs.net

When the policy/function involves patients/staff/partners/stakeholders etc please where possible include them in the Equality Analysis to demonstrate openness, transparency and inclusion and particularly by those who this policy/function is most likely to have impact.

Does this Policy/Function have any potential or actual impact that is positive(+), neutral (N) or negative (-) impact on the following protected characteristics please indicate:				
	+	N	-	Please provide a rational/justification for <u>each</u> of the following regardless of impact
Age		N		This policy is for all staff in the trust and relates to information and data.
Disability			X	There may be a potential for staff with visual impairment to have difficulties regarding reporting as it is via a personal computer, and arrangements can be in place to support the member of staff to complete reporting if required
Gender Reassignment		N		This policy is for all staff and relates to data quality and would be applicable to all individual regardless of gender reassignment.
Pregnancy & Maternity		N		This policy is for all staff and relates to Data Quality. The processes would be the same regardless of a woman being pregnant or not.
Race		N		The policy would be applied in the same way regardless of 'race', there are no known negative impacts on any group of people to any lessor or further degree than other groups
Religion & Belief		N		The policy would not have a negative impact on any

				individual on religious or belief grounds.
Sex		N		This policy applies to men and women in the same way
Sexual orientation		N		This policy is for all staff and relates to data qulity regardless of sexual orientation
Marriage & Civil Partnership		N		This policy is for all staff and relates data quality. There would be no difference in the application of the policy as a result of an individual's marital status.

Other Groups who could experience inequality, eg carers, homeless, travelling communities, unemployed, people resident within deprived areas, different socio/economic groups eg low income families, asylum seekers/refugees, prisoners, people confined to closed institutions or community offenders, people with different work patterns eg part-time, full-time, job-share, short-term contractors or shift workers - *Access, location and choice of venue, timings of events and activities. Support with caring responsibilities*
No other groups would experience inequality as a result of this policy.

Analysis conducted by: (minimum of 3 people)			
	Name	**Job Title**	**Contact details**
1	Ofrah Muflahi	Deputy Head of Quality Governance	Ofrah.muflahi@hacw.nhs.uk
2	Della Lewis	Head of Quality Governance	Della.lewis@hacw.nhs.uk
3	Kerry Beaumont	Compliance Manager	Kerry.beaumont@hacw.nhs.uk

Start date of policy/function	December2015	**Period valid for :** 3 years
Review date of policy/function		

Service Delivery Unit:		Corporate Quality and Safety Team						
Reference/Version:	V6	**Date Equality Analysis completed**:	D	D	M	M	Y	Y
			2	7	1	1	1	5

If you have identified a potential discriminatory impact on the policy/function please refer it to the author together with suggestions to avoid or reduce the impact.

A copy of the completed Equality Analysis must be attached to the policy/function and a copy sent to:

Patrick McCloskey
Equality Inclusion Practitioner
Isaac Maddox House, Shrub Hill Road, Worcester, WR4 9RW
Tel: 01905 761324
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