York Teaching Hospital
NHS Foundation Trust

Data Quality Policy

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Target audience:	All Staff
Relevant Regulations and Standards	Information Governance CQC – Outcome 21
Links to Organisational/Service Objectives, business plans or strategies	Information Governance

Executive Summary

This policy describes the process to ensure that the quality of data collected is consistent across the Trust and that all levels of staff comply with this.

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
3.0		FCJ	Draft for presentation to March Board Meeting	Conformed to new Policy template. Updated to include requirements of Payment by Results, Information Governance Standards
3.1		NS		Additions: Six dimensions Scope, Organisation Chart, NHS number, Importance of Data Quality, Training, Validation, Summary Amendments Care Quality Commission name change
3.4		NS		Document review required Update to titles and departments
4.0	January 2015	NS	Approved - Staffroom	Integrated and updated document
4.1	March 2018	NS	Approved - Staffroom	Updated organisation names as appropriate

Contents

1 Introduction & Scope

1.1 Introduction

1.1.1 Reliable information is fundamental in supporting the Trust to achieve its goals. The Trust recognises that all the decisions, whether clinical, managerial, operational or financial need to be based on information which is of the highest quality. The Trust recognises the importance of reliable information and views Data Quality as critical to the delivery of better healthcare.

1.1.2 A vast amount of information is recorded when treating patients in York Teaching Hospital NHS Foundation Trust. Having accurate, relevant information that is accessible at the appropriate times is essential to each and every clinical or business decision and to the success of the service provided. With this in mind, it is essential that all employees of the Trust recognise the importance of Data Quality during the execution of their duties.

The Department of Health, NHSE, Care Quality Commission and the Audit Commission have made it clear that all NHS Trusts are required to deliver significant improvements in the accuracy of data that underpins the Performance Framework and National Operational Framework.

1.2 Scope

1.2.1 It is the responsibility of all Clinical and Corporate Directors to ensure that the quality of data collected is consistent across the Trust and that all levels of staff are aware of the requirements of the policy. All managers, Directors, Directorate Managers and Heads of Department have a shared responsibility for ensuring that best practice is observed in their operational area in line with NHS Information Governance guidelines.

1.2.2 Every member of staff has a responsibility for data quality and this in turn should be reflected in all the policies and procedures practiced in the Trust by staff at all levels. Improving information and data quality is an important task. It requires a multi strand approach that addresses the whole range of activities from basic data collection through to the application of information analysis and knowledge.

2 Definitions / Terms used in policy

Data quality can be described using six key characteristics or dimensions, as identified by the Audit Commission. These dimensions

will assist the Trust in assessing the quality of data held and take action to address potential weaknesses.

Dimension	Description
Accuracy	Data should be sufficiently accurate for its intended purposes, representing clearly and in sufficient detail the interaction provided at the point of activity. Data should be captured only once, although it may have multiple uses. Accuracy is most likely to be secured if data is captured as close to the point of activity as possible. Reported information that is based on accurate data provides a fair picture of performance and should enable decision making at all levels. The need for accuracy must be balanced with the importance of the uses of the data, and the costs and efforts of collection. For example, it may be appropriate to accept some degree of inaccuracy where timeliness is important. Where compromises have to be made on accuracy, the resulting limitations of the data should be clear to its users.
Validity	Data should be recorded and used in compliance with relevant requirements, including correct application of any rules or definitions. This will ensure consistency between periods and with similar organisations. Where proxy data is used for an absence of actual data, consideration must be given to how well this data is able to satisfy the intended purpose.
Reliability	Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.

Dimension	Description
Timeliness	Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Relevance	Data captured should be relevant to the purposes for which it is used. This entails periodic review of requirements to reflect changing needs. It may be necessary to capture data at the point of activity which is relevant only for other purposes, rather than current intervention. Quality assurance and feedback processes are intended to ensure the quality of such data.
Completeness	Data requirements should be clearly specified based on the information needs of the organisation and data collection processes matched to those requirements. Monitoring missing, incomplete, or invalid records provides an indication of data quality and can also point to problems in the recording of certain data items.

3 Policy Statement

3.1 Every member of the Trust has a fundamental responsibility for protecting the integrity and confidentiality of the information that they work with. This is a legal and contractual duty, reinforced for many staff groups by their professional Codes of Conduct and clearly stated in the Trust's Information Security Policy.

3.2 Failure to comply with the policy could have consequences for the Trust in terms of adversely affecting patient care, loss of capacity, reputation loss and/or failure to establish correct levels of revenue.

3.3 Spending time ensuring that data is as accurate as possible when dealing with patient contact, patient and staff experience and all matters of Trust business and activities is fundamental to the delivery of high quality data. It is crucial to patient safety, the operational management of the hospital, clinical audit, contracting and Payment by Results that information is accurate and reliable.

3.4 The Trust has endorsed that CPD is the primary patient record throughout the organisation.

3.5 The Trust will ensure that it uses standard definitions, values and validation programmes and that they are incorporated within key systems, this includes ensuring that the NHS number is included for each active patient.

3.6 The Trust will ensure that all staff routinely check information about patients with the source and ensure that corrections are made as necessary.

3.7 The Trust will have a robust programme of internal and external audit covering the quality of clinically coded data which meets the requirements of the Audit Commission, Care Quality Commission and NHS Digital.

3.8 The Trust will have a robust programme of internal and external audit covering the quality of financial data (including feeds from other systems) which meets the requirements of NHSI and complies fully with prevailing accounting standards*.*

4 Importance of Data Quality

Quality information is essential for:

- Patient care; enabling the delivery of effective, relevant and timely care, as well as minimising clinical risk.
- Efficient administrative and clinical processes including communication with patients, their families and other carers involved in the patient's treatment.
- Management and strategic planning, requiring accurate data about the volume and types of patient activity and the population health needs to provide appropriate allocation of resources and future service delivery.
- Clinical governance depends on detailed, accurate patient data for the identification of areas where clinical care could be improved.
- Providing information for other NHS organisations.
- Being able to benchmark the Trust against other organisations.
- To facilitate and maintain the accurate flow of information between the Trust and external agencies.
- Planning, monitoring and accounting for the use of public resources in delivering the Trust's objectives.

- Effectively managing employees of the Trust and ensuring compliance with all aspects of employment law.

5 NHS Number

5.1 Importance of the NHS Number

The NHS number is the only unique way of identifying patients across the NHS. With this in mind, it is imperative that this is recorded correctly and in all systems where patient information is present. The Trust has adopted the stance that the NHS number should also be included on all correspondence about patients, e.g. referral forms and letters. This helps to ensure correct identification of patients in question.

6 Validation

6.1 Importance of Validation

Validation encompasses the processes that are required to ensure that the information being recorded is of good quality. These processes deal with data that is being added continuously and also can be used on historical data to improve its quality.

It is imperative that regular validation processes are undertaken on data being recorded to assess its completeness, accuracy, relevance, accessibility and timeliness. Such processes may include checking for duplicate data, validating waiting lists, ensuring that national definitions and coding standards are adopted and NHS number is used and validated.

6.2 Validation Methods

6.2.1 Validation should be accomplished using either of the following methods:

- Exception reporting can be used as an initial Data Quality tool as this will quickly highlight any areas of concern however, further investigation will be required to identify more specific issues.
- Spot checks should be done on an ongoing regular basis to ensure the continuation of Data Quality.

6.2.2 Appropriate use of internal and external audit checks should also be made, ensuring relevant frequency of checks and compliance with any statutory and/or best practice requirements.

6.3 Data Standards

6.3.1 The use of data standards within systems can greatly improve Data Quality. These can be incorporated into systems either using electronic selection lists within computer systems or manually generated lists for services that do not yet have computer facilities. Either method requires the list to be generated from National or locally agreed definitions and must be controlled, maintained and updated in accordance with any variations that may occur. Any documentation that refers to the data standards must also be updated as needed and disseminated to all relevant parties.

6.3.2 Providers of data should also ensure that they are able to comply with data accreditation, health records accreditation appropriate financial and employment records legislation and undertake routine Data Quality audit and quality monitoring. Data Quality is an essential part of the overall information governance framework and reference to the IG toolkit is a requirement for all data providers. The legislative framework within which data standards should comply includes:

- Data Protection act 1998
- Freedom of information Act 2000
- Human right act 1998
- Access to health records act 1990
- Computer misuse act 1990
- National Health services Act 1977

6.4 External Sources of Data

The validation process should use accredited external sources of information, for example, the SPINE to check NHS number, GP details, data pertaining to Secondary Uses Services (SUS) and Payment By Results (PBR).

6.5 Source Data

Staff involved with recording data need to ensure that it is performed in a timely manner and that the details being recorded are checked with the source at every opportunity. In the case of patient data this could be by cross checking with patient records or by asking the patients themselves.

6.6 Synchronising Information Systems

In situations where data is shared between systems it is imperative that the source data be validated initially. Any modifications made to this data must then be shared with other related systems ensuring there are no inconsistencies between them. These systems must then be examined and authenticated in turn. Continuous synchronisation between systems is required to guarantee that all data sources reflect the same information.

6.7 Timescales for Validation

Where inconsistencies are identified these must be acted upon in a timely fashion and documented. Locally agreed deadlines will apply to the required corrections but all amendments should be made within a maximum of two months from the identification date.

7 Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 1.

8 Accountability

Operational implementation, delivery and monitoring of the policy resides with:-

8.1 The overall accountability for all Data Quality lies with the Chief Executive of the Trust. The Chief Executive has the lead responsibility for Data Quality and is supported operationally by the Director of Systems and Network Services and Finance Director (who is the Trust's Senior Information Risk Officer - SIRO).

8.2 All managers, Directors, Directorate Managers and Heads Of Department have a delegated responsibility for ensuring that prevailing legal requirements and best practice is observed at all times for all data.

8.3 The Data Quality Team within Systems and Network Services has been established to act as a source of good practice. The team are responsible for the continual validation of patient related data, Data Quality audits and identification of issues pertaining to patient related Data Quality that need to be addressed.

8.4 Any individual identifying a data quality issue is responsible for either addressing the identified issue, or escalating the problem to their senior manager. All staff members will be in contact at some time with a

form of information system, whether paper or electronic based. As a result, all staff members are responsible for implementing and maintaining Data Quality and are obliged to maintain accurate records legally (Data Protection Act), contractually (contract of employment) and professionally (professional code of conduct).

A vast amount of information is recorded when treating patients in York Teaching Hospital NHS Foundation Trust. Having accurate, relevant information that is accessible at the appropriate times is essential to each and every clinical or business decision and to the success of the service provided. With this in mind, it is essential that all employees of the Trust recognise the importance of Data Quality and their responsibilities in this area.

Appendix 1: Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	Data Quality Policy
1.	**What are the intended outcomes of this work?** *Include outline of objectives and function aims* Ensure quality of data held electronically throughout the Trust
2	**Who will be affected?** *e.g. staff, patients, stakeholders etc* All staff
3	**What evidence have you considered?** *List any examples of good practice you have used in putting this policy together, ensuring consideration to the ability to implement the policy by he following groups has been given* Audit Commission Data Assurance Framework This policy is intended to ensure all patients are treated equitably and in line with NHS England guidance
a	**Disability** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
b	**Sex** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
c	**Race** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
d	**Age** . This policy is inclusive and does not differentiate between people on the basis of this characteristic.
e	**Gender Reassignment** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
f	**Sexual Orientation** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
g	**Religion or Belief** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
h	**Pregnancy and Maternity**. This policy is inclusive and does not differentiate between people on the basis of this characteristic.

i	**Carers** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
j	**Other Identified Groups** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	See comments in d
b.	How have you engaged stakeholders in constructing the policy	See comments in d
c.	If so, how have you engaged stakeholders in constructing the policy	See comments in d
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs **This Policy is based on NHS England best practice and guidelines to ensure that our data quality processes and procedures are equitable for all patients requiring our services**	
5.	**Consultation Outcome** **This Policy is based on NHS England best practice and guidelines which is aimed at eliminating discrimination and to ensure equality for all our patient groups in the implementation of our Data Quality Policy** *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	Neutral Impact
b	Advance Equality of Opportunity	Neutral impact
c	Promote Good Relations Between Groups	Positive impact
d	What is the overall impact?	Improve Data Quality
	Name of the Person who carried out this assessment:	
	Date Assessment Completed Nov 2014	
	Name of responsible Director S Rushbrook	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix 2: Policy Management

1 Consultation Process

The Trust will involve stakeholders in the development of its policies.

Consultation has taken place with the following stakeholders:

- Systems and Network Services
- Information Governance Team
- Internal Audit

It has been considered by the Data Quality and Performance Working Group (a sub committee of the Audit Committee.

2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy has been through quality assurance checks prior to being reviewed by the authorising committee to ensure it meets the standards for the production of policy and equalities legislation and is compliant with the Development and Management of Policies policy.

3 Approval Process

The approval process for this policy complies with that detailed in section 6.3 of the Development and Management of Policies Policy. The approving body for this policy is Executive Board.

The Checklist for Review and Approval has been completed and is included as Appendix 2.

4 Review and Revision Arrangements

On reviewing this policy, all stakeholders identified in section 9.1 will be consulted. The person responsible for review are:

- The author of the policy

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Executive Board.

5 Dissemination and Implementation

Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Hospital NHS Foundation Trust following the completed Plan for dissemination of the policy (See Appendix 3)

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

Implementation of Policies

This policy will be implemented throughout the Trust by all staff who are responsible for ensuring the accuracy of data.

In addition to this the Policy Author will collate the following evidence to demonstrate compliance with this policy:

- Data Quality reports

- Audit Reports

6 Document Control including Archiving Arrangements

Register/Library of Policies

This policy will be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal's search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

Archiving Arrangements

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

It is the responsibility of the Healthcare Governance Directorate to ensure that version history is maintained on Staffroom and Q-Pulse.

Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

7 Standards/KPIs

The Trust Data Quality programme is driven by the need to provide assurance of the robustness of data underpinning national key performance indicators. This is reviewed annually to incorporate any changes to national data collections underpinning local performance and any changes to the National Payment by Results (PbR) Strategy.

Standards governing the accuracy and timeliness of data are derived from legislation, standards, best practice and NHS Guidelines including the Information Governance Toolkit.

8 Training

The Trust will have training programmes for all staff involved in data collection and management. Training will be supported by documented procedures.

Line managers are responsible for identifying the training requirements of their staff and working with training providers to ensure these needs are met. Staff must be enabled to attend the appropriate training courses allowing them an adequate level of proficiency in order to carry out their functions effectively.

9 Trust Associated Documentation

This policy is supported by Systems and Network Services and Information Services procedures.

- Information Security Policy
- Data Protection Policy.

- Management and Maintenance of Records Policy.
- Information Governance Policy.
- NHS Number Allocation Strategy.

Specifically in the case of financial data the following related documents include:

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation

10 External References

- http://www.dh.gov.uk/en/index.htm
- http://www.cqc.org.uk/
- http://www.auditcommission.gov.uk/Pages/default.aspx
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009190
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

11 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below:

11.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements of the NHSLA Risk Management Standards for Acute Trusts are met, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Monitoring of data quality	By the Data Quality Programme	Head of Internal Audit	Annual	Director of SNS	Information Team Leader	Information Manager
b. Monitoring of quality of patient related data	Sample audit of key performance data	Information Manager	Weekly	Director of SNS	Information Team Leader	Information Manager
c. External body assurance of data quality	External audit of data quality	Monitor	Annual	Director of SNS	Information Team Leader	Information Manager

Appendix 3: Plan for the dissemination of a policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Data Quality Policy
Date finalised:	March 2018
Previous document in use?	Yes
Dissemination lead	Nicky Slater
Which Strategy does it relate to?	Improve our effectiveness, capacity and capability Improve quality and safety
Format	Electronic
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**

To be disseminated to:	All Staff
Method of dissemination	Electronic
Who will do it?	Policy author to key staff Policy Manager via publication on Staffroom
and when?	On approval
Format (i.e. paper or electronic)	Electronic

Dissemination Record

Date put on register / library	March 2018
Review date	March 2020
Disseminated to	As above
Format (i.e. paper or electronic)	Electronic
Date Disseminated	March 2020
No. of Copies Sent	Refer to policy author
Contact Details / Comments	Policy author

Appendix 4: Checklist for Review and Approval

Authors need to be confident that their policy meets all of the criteria identified below before submitting this to the appropriate committee(s) for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Development and Management of Policies**		
	Is the title clear and unambiguous and meets the requirements of page 3 of the Development and Management of Policies Policy?	Yes	
	Is it clear whether the document is a policy, procedure or protocol?	Yes	
	Does the style and format of the policy meet the requirements of section 3.2 of the Development and Management of Policies Policy?	Yes	
	Does the policy contain a list of definitions of terms used?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with all relevant stakeholders and users?	Yes	
4.	**Content**		
	Is the document linked to a strategy?	No	
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Does it meet all of the requirements of NHSLA RMSAT or other relevant body, if applicable?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are supporting references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
	Are all associated documents listed and updated?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	n/a	
7.	**Dissemination and Implementation**		
	Does the dissemination plan identify how this will be done and is it clear?	Yes	
	Does the plan include the necessary	Yes	

	Title of document being reviewed:	Yes/No	Comments
	training/support to ensure compliance?		
	Does the policy detail what evidence will be collated to demonstrate compliance with it?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	No	
	Is there a plan to review or audit compliance with the document?	Yes	Regular DQ monitoring
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation, evidencing, monitoring and review of the documentation?	Yes	

Policy Owner's Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval. (This can be completed electronically with an electronic signature)			
Name	S Rushbrook	Date	Nov 2014
Signature	*S Rushbrook*		

Committee Approval			
If the Chair or Vice Chair of the committee is happy to approve this document, please sign and date here and enter the name of the committee/group. The Policy Author will contact the secretary/administrator of the committee/group to obtain a signed copy of this checklist. The Policy Author will then submit this together with the approved policy (ensuring the "draft" watermark is removed) to the Policy Manager for logging and publication.			
Name	M Proctor	Date	21 January 2015
Signature	*Mike Proctor*		
Committee/ Group title	For an on behalf of Executive Board		

For Policy Manager's use only	
Is there a signed and completed Checklist for Review and Approval accompanying the policy?	Y
Is the policy logged on Q-pulse?	Y
Has the old version of the policy been archived? (if applicable)	Y
Has the policy been published on Staffroom?	Y
Author notified that policy has been published?	Y