

## Data Quality Management Strategy 2013-16

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Key terms	
Name	Description
RiO	Electronic Patient Record used widely across the Trust
IAPTUS / PC-MIS	Electronic Patient Record used in IAPT services
MLE	Managed Learning Environment
ESR	Electronic Staff Record
Agresso	Finance system
PaCMAN	Performance & Contract Management Meeting
CPMG	Contract & Performance Management Group
IQ	Trust's Quality Information System

## 1. Introduction

High quality and meaningful information enables people at all levels in the Trust (and external stakeholders), from the frontline to Board to:

- Judge our service quality and outcomes; and monitor progress
- Make strategic and service decisions, based on evidence
- Investigate or diagnose suspected problems, or evaluate service/practice changes
- Benchmark the Trust, against other Trusts, or internally across services

Information derived from the Trust's electronic systems is a key component of this, and thus assuring the quality of the data held by the Trust is of crucial importance.

### 1.1 Francis report: recommendations

The Francis report (2013) contains a number of recommendations where the use of high quality information is crucial. Some of the key recommendations are included below, however the full report should be referred to in order to gain the full context:

- The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners
- A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible
- Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them
- Commissioners must have the capacity to monitor the performance of every commissioning contract [...]:
  - Such monitoring may include requiring quality information generated by the provider
  - The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation
- Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed
- The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved

## 2. Purpose

The purpose of this document is to set out the Trust's approach to data quality management and the strategic direction for the next three years.

### 3. Scope

The principles outlined in this strategy are applicable to all data held on all electronic systems. Examples include:

- Electronic Patient Record (e.g. RiO, IAPTUS, PC-MIS, Theseus)
- Staff Record Systems (e.g. ESR, MLE)
- Agresso (Finance system)
- Ulysses (Incident reporting tool)

### 4. Defining Data Quality

#### 4.1 Definitions

For the purpose of this document the following distinction is applied:

- **Data** - what is entered on a system and any unanalysed data reported out
- **Information** – the analysed, presented or interpreted output from data entered

#### 4.1 'Figures you can Trust'

The Audit Commission provide a useful framework for defining and then managing data quality in their 'Figures you can Trust' report published in 2009. In this document, six dimensions of data quality are identified which, when suitably addressed, will support an organisation to achieve good levels of data quality. These dimensions are included in the table below.

This strategy outlines how each of these dimensions is attended to, drawing on explicit examples, and identifies where gaps are known and actions underway to address.

In addition, it should be noted that there is no 'absolute standard' for data quality that can be applied universally, therefore these principles will need to be applied as part of a continuous improvement approach, reviewed and evaluated regularly.

Table 1: Dimensions of Data Quality

Timeliness	Data captured quickly after the event, and made available for use as quickly as possible
Completeness	The extent to which data is complete (e.g. how many missing records are there)
Validity	Data is recorded and used in accordance with any rules / definitions (allowing for comparison)
Relevance	Data should be relevant for the purpose for which it is being used
Reliability	Data should be based on stable and consistent collection processes (danger that improvements in performance reflect changes in collection, rather than practice)
Accuracy	How 'correct' is the data

## 4.2 Information Governance Toolkit

The Information Governance Toolkit has a number of requirements that relate to data quality assurance and the approach within this strategy ensures compliance with these requirements – which in doing so further promotes the quality of the Trust’s data. These requirements are:

- 502: External data quality reports are used to monitor and improve data quality
- 504: Use of local & national benchmarks to identify data quality issues
- 506: Regular audit cycle for accuracy of service user records
- 507: Completeness & Validity check
- 508: Clinical staff are involved in validating information relating to clinical care
- 514: Audit of clinical coding

## 4. Links to the Performance and Quality Management Strategy

This strategy sets out the approach to supporting the delivery of good data quality across the Trust. Where issues of poor data quality are identified, improvement will be delivered in accordance with the principles set out in the Trust’s Performance & Quality Management Strategy and therefore this document should be viewed as supporting / underpinning that strategy. Key principles, in brief:

- IQ underpins the quality / performance ‘conversation’
- Monthly review / challenge of data, via:
  - Internal: Quality Huddle, PaCMAN, Locality Meetings, Team / ward meetings, supervision
  - External: CPMG, Local CPMG

## 5. Ensuring Data Quality

### 5.1 Timeliness

#### 5.1.1 Timelines (data entry)

The Trust has set a standard for the timeliness of data entry for all of its electronic patient record systems as follows:

- Inpatient / intensive services: within 24hrs of the event
- Community services: within 3 working days of the event

This standard will be monitored via a ‘Data quality: timeliness’ metric within the Quality Information System (IQ) and reported both internally and externally, via the Quality and Performance Report, on a monthly basis. A target of 95% has been set for this metric. ***The full list of data quality metrics used by the Trust is detailed in Appendix A.***

#### 5.1.2 Timeliness (reporting)

The Trust will consider the ‘time taken’ to report whenever information is due to be published and aim to minimise the delay between data collection and

publication as much as possible. IQ, which contains a range of metrics from a range of systems, is updated monthly as a minimum and in some cases more frequently. For example:

- **Friends & Family, Records Management & CQC Compliance audits:** these domains are all updated on a monthly basis, within 3 working days of the end of the previous month
- **Monitor & Contract Compliance & Supervision:** both these sections are updated daily

## 5.2 Completeness

The Trust will monitor all nationally defined completeness metrics. In addition, the completeness of records in the systems that underpin key local reports / indicators will be considered, and where necessary a metric will be introduced to monitor this aspect of data quality (which will be reported monthly internally and externally). Examples of the above already in place include:

### 5.2.1 Monitor Compliance

The Trust uses the two data completeness metrics detailed by Monitor, these are:

- Data quality: identifiers (which monitors the completeness of core fields within the patient record, e.g. date of birth, GP, postcode)
- Data quality: outcomes (which monitors the completeness of key outcomes fields)

### 5.2.2 CQC Compliance, Records Management and Friends and Family

The Trust underpins the scores achieved for these quality indicators by publishing 'completeness' metrics alongside the scores, in the form of the percentage of teams and wards that submitted a return for the first two, and the response rate by service users for Friends and Family.

### 5.2.3 Staff related indicators (sickness, supervision, appraisals)

The Trust reports these indicators based on 'whole population', rather than a sample basis, to ensure all staff are included in the reporting.

### 5.2.4 Completeness & Validity check (507)

In order to support delivery of the IG toolkit, the Trust will monitor performance against the Completeness and Validity check and report progress to the Information Governance Management Group.

## 5.3 Validity / relevance

The Performance and Quality Management Strategy sets out the requirement for an annual review of the high level domains within IQ, as well as a review of all

Contractual indicators. This process will ensure the validity and relevance of the reports in place.

## **5.4 Reliability**

The Trust will ensure that all data entry into clinical and business systems is supported by suitable guidance documentation to ensure reliability. This will be supported by a centrally coordinated training programme where necessary (e.g. RiO training), where training packages are constructed around the core guidance available.

### **5.4.1 Clinical Systems Management**

For clinical systems, this process coordinated by the Clinical Systems Manager (and team) to ensure that all guidance and training that support clinical systems is synchronised and fit for purpose. Links to guidance / policy are included in Appendix B.

### **5.4.2 Clinical Academy**

The Clinical Academy provide high level oversight of clinical system usage and will ensure that processes included in guidance and training are clinical intuitive, and importantly support quality improvement across the Trust.

## **5.5 Accuracy**

The Trust will ensure that records within clinical and business systems are regularly validated to ensure accuracy.

### **5.5.1 The electronic patient record (Records Management Audit)**

The Trust has in place a monthly Records Management audit that requires each team and ward to manually audit 5 randomly selected service user records. Each record is audited against 10 centrally defined elements. Team / ward level results are then included within IQ and monitored as part of the Performance and Quality Management monthly cycle. These audits are undertaken by frontline clinicians. Estimate for 2013-14 is that 750 individual records are review each month, which equates to 7,500 individual elements of the care record being clinically assessed for quality and accuracy on a monthly basis.

This element of the data quality assurance process underpins the Trust's compliance with IG Toolkit requirements 506 (cycle of audits) and 508 (clinician involvement in validating records).

### **5.5.2 Auditing the quality of clinical coding**

To support compliance with IG Toolkit requirement 514, audit of clinical coding, the Trust will include an audit of clinical coding as part of the CQC Compliance

element of IQ – requiring 10 records to be audited each month, for each team and ward, and checked for accuracy. This information will be made available via the IQ system so that performance can be monitored and issues of accuracy addressed.

### 5.5.3 The Quality Information System (IQ): total transparency

The IQ system provides the organisation with opportunity to view, and challenge, information being presented using local knowledge and experience. This openness allows for opportunity to check accuracy and make corrections where necessary. Relevant features of the system are:

- **Open access:** any member of the Trust can access any part of IQ and view the information therein (except areas that contain patient level data, where access restrictions are in place)
- **Drillable:** the system provides reports that can be drilled into, from Trust, to local delivery unit, to team or ward and onto patient / staff level.
- **Range of information:** the system combines information from different systems (e.g. RiO, Agresso, ESR, MLE) and shows them alongside each other – delivering transparency and validation across multiple systems, not just the electronic patient record.

## 5.6 Benchmarking

### 5.6.1 Internal Benchmarking

The IQ system has been designed to allow for internal benchmarking across all high level domains and their sub-components. The system allows:

- Benchmarking at locality & team type level.
- Users can ‘self-select’ their peers. For example, a Recovery team manager may choose to benchmark themselves against other teams in their geographic area, or Recovery teams in other parts of the Trust.

### 5.6.2 External Benchmarking (including external data quality reports)

The Trust is a member of the NHS Benchmarking Network, and sits on the Mental Health Reference Group which develops the annual benchmarking exercise. The results of this annual exercise will be analysed and shared internally and where applicable, the IQ system will be expanded to add national benchmarks as further context to the information presented.

In addition, the Information Governance Management Group received a quarterly Data Quality Report that provides an update on all internal data quality metrics, as well as nationally reported data quality metrics (i.e. to provide assurance that internally created data is accurate).

The combination of 5.6.1 and 5.6.2 underpin the Trust’s compliance with IG Toolkit requirements 502 (external data quality reports) and 504 (internal and external benchmarking).

## **6. Next steps for further improvement**

### **6.1 Corporate Systems & Data Quality**

The Trust will seek to strengthen the data quality monitoring for corporate systems to ensure that levels of assurance are comparable to clinical systems. Including, where appropriate, centralising the reporting of corporate information to maximise efficiency, develop a reporting 'brand', and to reconcile core data across multiple systems. Timescale: by April 2014

### **6.2 Peer review within clinical records auditing**

The Trust will implement a systematic peer review process to underpin the assurance reported via the Records Management and CQC Compliance domains within IQ (both of which are 'self-reported' at team and ward level). Timescale: agree approach by Dec 2014, implement during Q4, 2013-14.

### **6.3 Development of an Information Strategy**

The Trust will develop and Information Strategy to set out the Trust's approach in this area. Specifically to:

- Develop a systematic approach to understanding the Trust's information needs
- Ensuring information systems are utilised to their full potential and duplication / redundancy is removed

Time scale: Q4, 2013-14

## Appendix A: list of data quality metrics (for 2013-14)

Source	Description
Monitor	Completeness of outcomes
Monitor	Completeness of identifiers
Local	Timeliness
PbR	Cluster: completeness of cluster
PbR	Cluster: timeliness of review for clusters
PbR	Cluster: compliance with transition protocols
PbR	Cluster: compliance with red rules
Local	Completeness of ethnicity
Local	Completeness of protected characteristics

## Appendix B: links to clinical systems guidance / policy

How to use RiO (home page)

<http://ourspace/Systems/RiO/Pages/Home.aspx>

User training guides

<http://ourspace/Systems/RiO/Pages/UserGuides.aspx>

RiO usage process maps

<http://ourspace/Systems/RiO/Pages/Processmaps.aspx>

RiO WIKI (procedures for recording and accessing clinical information)

<http://ourspace/Systems/RiO/ClinicalSupport/Wiki%20Pages/Home.aspx>