Our Ref: LW/lmw/FOI.155.23
Date: 9th June 2023

Laurie Wrench
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
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Tel 01782 275030

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 16th May 2023**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
Clinical Coding

- Please can you share a copy of your Clinical Coding policy if you hold this information? **Please see Appendix 1 attached**
- Please can you share if you hold any Standard Operating Procedures, Guidance, process guides for the clinical coding function? **N/A**

Data Quality

- Please can you share a copy of your Data Quality policy if you hold this information? **Please see Appendix 2 attached**
- Please can you share if you hold any Standard operating Procedures, Guidance of process guides for staff working in the Data Quality Function? **N/A**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

L. Wrench.

Laurie Wrench
Deputy Director of Governance

North Staffordshire Combined Healthcare NHS Trust

Doc level: Trustwide
Code ref:7.10

Inpatient Clinical Coding Policy & Procedures

Lead executive	Director of Strategy
Authors details	Health Records & Information Governance Manager

Type of document	Policy
Target audience	All Trust staff
Document purpose	This policy is to ensure that the Trust provide accurate, complete and timely clinically coded information for finished consultant episodes to support the Clinical and Information Governance process. To support commissioning, local information requirements and the information for Commissioning Data sets (CDS), Mental Health Minimum Data Set (MHMDS) and Central returns on behalf of the Trust. It is currently a national requirement that all Finished Consultant Episodes (FCE's) for in-patients are assigned an International Classification Diseases (ICD 10) diagnosis code.

Approving meeting	Audit Committee Trust Board	Meeting date	4 December 2020 14th January 2021
Ratification date	15th January 2021	Review date	31st January 2024

Trust documents to be read in conjunction with	
Document code	Document name
7.01	Confidentiality of Patient and Employee Personal Information Policy
7.07	Records Management Policy
7.13	Data Quality Policy

Document change history		Version	Date
What is different?	– It has been reviewed and updated in line with digital developments in the Trust – It has been reviewed and updated in line with any national developments		
Appendices / electronic forms	–		
What is the impact of change?	– Minimal changes in line with any digital changes		

Training requirements	

Document consultation	
Directorates	Circulated to the QIL's for circulation as appropriate within the directorates, Inpatient Consultants & Nurse Practitioners. Policy approved by the IG Steering Group
Corporate services	
External agencies	

Financial resource implications	No

External references
1. DOH; Records Management Code of Practice

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	

– **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, looked after children, local authority care leavers, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Table of Contents

1. Policy Statement

This policy is intended to promote good practice and consistency of information produced during the clinical coding process for inpatient activity. It is based on guidance from Health and Social Care Information Centre and has been designed to incorporate the requirements of the Data Accreditation process to ensure information produced during the coding process is accurate and adheres to local and national policies.

There is a need to ensure that the quality of clinical coding within the organisation is maximised to ensure that the correct levels of clinical activity are recorded and reported on by the organisation. A classification scheme is the bedrock for developing a mechanism that delivers an equitable funding system.

This Policy and associated procedures conform to national requirements already in existence and other local procedures which affect the coding process, such as patient administration, patient discharge, the recording of deaths, clinical record documentation and clinical record flow. A good procedure should be explicit about who is responsible for what, how, when and where.

All procedures involved in the capture of information for inpatient clinical coding purposes are clearly defined in this Policy and Procedure document for all specialties to ensure compliance and clarification of individual coding processes.

All quality assurance procedures for Clinical Coding are detailed in this Policy and Procedure document including audit and data quality measures, to ensure continual improvements in the standard and quality of coded data in the Trust.

All changes to clinical coding policies and procedures are detailed in this document, in the appropriate manner, to ensure all contributors are in agreement with the current practice. Any alterations to clinical coding practice have change and implementation dates provided within this document, and comply with national standards and classification coding rules and conventions. Also please refer to the Standard Operating Procedure for ROSE (NSCHT30 –Coding)

The Trust has services that are commissioned separately from the Trusts main contracts. These services have to maintain and collate information in line with the requirements of their commissioners. They will complete clinical coding in line with the commissioned contracts. These services will be responsible for completing a Standard Operating Procedure (SOP) as to how they will complete clinical coding for their requirements. Current service list:-

- Substance Misuse Service

Training plans for clinical coding staff are clearly defined and documented in this document (appendix 4).

Details of communication arrangements are detailed in this document to ensure effective dissemination of information regarding coding, resolutions to queries and changes in coding practice to all coding staff and users of the information.

All confidentiality and security issues incurred during the coding process are detailed in this document to ensure adherence to local policies and National Standards have been agreed by the Trust.

Some of the terms used in this policy are not the preferred and typical terms used to describe clinical conditions experienced by users of mental health and learning disabilities services, for example, mental retardation to mean learning disability and holiday relief to mean respite care. These terms are deliberately applied in this policy and set of procedures to ensure consistency of terms used in the International Classification of Diseases (ICD-10) manual and other coding sources. (Also refer to the Standard Operating Procedure; NSCHT – 30 Coding)

2. Scope

All in-patient areas of the Trust are covered by this procedure unless identified as above because of the way that the service is commissioned.

3. Framework

Clinical coding is the allocation to each clinical record of codes selected from the National Standards to facilitate ease of data retrieval and direct comparability between patients with similar morbidities.

High quality coding allows for:

- An assessment of health care needs
- The sharing between healthcare organisations and clinicians of standardised records
- Effective resource management
- Medical and clinical audits to be carried out more easily
- Ease of use in epidemiological study (study of diseases) and aetiology study (Cause and origin)
- The capture of data necessary for tariff-based systems of remuneration.

To provide accurate, complete and timely clinically coded information for inpatient activity to support Clinical and Information Governance processes.

To support commissioning, local information requirements and the information for Commissioning Data sets (CDS), Mental Health Minimum Data Set (MHMDS) and Central returns on behalf of the Trust.

To ensure continual improvement of clinically coded information within the Trust through systematic audit and quality assurance procedures.

To adhere to national standards and classification rules and conventions as set out in the World Health Organisation ICD-10 Volumes 1-3, Clinical Coding Instruction Manual ICD-10 and OPCS-4 and publications of the Coding Clinic.

To support the clinical processes by allowing analysis and comparison of similar cases.

To revert to consultant in charge of the patient's care where clarification or further information is required in order to accurately code the discharge summary.

To input the diagnostic and operational codes into the electronic patient record system by the **5th working day** following the **month** in which the patient was discharged.

To produce and forward a monthly summary to the Trust's Medical Director showing completed patient episodes where a discharge summary has not been received by the clinical coder.

To maintain a log of all Notifications of Amendments to the Clinical Coding Instruction Manual ICD-10 and OPCS 4 and "Coding Clinics" inserts.

All new coding staff will be required to attend the Clinical Coding Foundation course within 6 months of appointment.

To ensure all staff involved in the clinical coding process receive regular training updates to maintain and develop their clinical coding skills.

All clinical coders to attend relevant specialist training courses as available.

To ensure all staff understand their commitments under the Trust's confidentiality policies.

To review the effectiveness of the Inpatient Clinical Coding Policy and Procedures on an agreed basis and approve amendments or continuance of use via the Quality Committee or any successor to this committee.

Reports of clinical coding performance will be made to the Clinical Records & System Design Group or any successor to this committee.

4. Clinical Coding Procedures

It is the Trust's policy that:

Inpatient clinical coding is accurate, complete, timely and consistent. Responsibility will lie with the consultant in charge for ensuring the provision of an accurate primary and where appropriate, secondary, diagnosis of the patient's condition, including the relevant ICD-10 and OPCS4 procedure codes where applicable.

All procedures involved in the capture of information for clinical coding purposes are clearly defined to ensure compliance and clarification of individual service coding processes.

All quality assurance procedures for clinical data coding are detailed in the policy and procedure document including audit and data quality measures, to ensure continual improvements in the standard and quality of coded data in the Trust.

The source document in use within the Trust is currently the discharge summary within the EPR. The Trust is committed to an improvement in the quality of clinical information provided for the purposes of coding procedures and clinical effectiveness systems generally. This is directly affected by the timescales currently in force within the Trust relating to clinical coding. Supplementary information is gained from:

Direct access to Combined Healthcare's clinical coding system (Lorenzo).

The consultant in charge of the patients care is responsible for ensuring the provision of an accurate diagnosis of the patient's condition **in full.**

Abbreviations are not to be used as they can describe more than one condition. For example, HTN – Hypotension or Hypertension.

Diagnoses

The Primary diagnosis is the main condition treated or investigated during the relevant episode of inpatient care.

In addition to the primary diagnosis, all relevant secondary diagnoses should be recorded on the discharge summary.

Secondary diagnoses might include:

- Other mental health conditions
- Conditions or problems dealt with during the episode of care
- Conditions which pre-exist in the patient for example: Epilepsy, Diabetes (whether insulin or non-insulin dependent), heart conditions, chest infection, asthma, hearing loss etc.
- Smoker, we have to capture patients who smoke:

a. Are they smokers when they come into hospital/centres
b. Are they on patches when they come into hospital/centres
c. Have they now gone onto a Smoking Cessation programme.

The secondary diagnoses must be recorded in order to accurately reflect the care received by the patient and to ensure that in any future tariff-based remuneration system the Trust receives adequate compensation for the full amount and range of treatment it has provided.

Discharge of patient

The consultant in charge of the patient's care is responsible for ensuring the discharge summary is completed at the point of the patient's discharge or as soon as possible after (within 48 hours)**.**

No diagnosis

It is highly desirable to obtain a diagnosis appropriate to the business of the Trust and its services for every in-patient episode of care. However it is understood that there are **occasions** when patients for whom no psychiatric or other diagnosis can be made. This normally occurs when the patient has not stayed in hospital long enough for a diagnosis to be made.

If a discharge summary is received by the clinical coder with a diagnosis of, for example, "no mental illness", the clinical coder will contact the consultant in charge of the patient's care to obtain a diagnosis. If this is not possible the consultant must explain the reason why the patient was admitted and can use the following code of Z03.2 Observation for suspected mental & behavioural disorder or ***the main symptoms, abnormal findings or problem should be selected as the main diagnosis"*** *if the Z code is not suitable.* This is in line with the National Coding Policy: "

Undifferentiated diagnosis

It is only acceptable for the clinical coder to code a definitive diagnosis. Any diagnosis given as "possible" or marked '?' will be ignored and if no other diagnosis is available the main symptom or other reason for admission will be coded. However if a diagnosis is marked "probable/treated" it will be coded in the ordinary way.

Coding of first episode when a patient has been transferred to another inpatient consultant or speciality

Patients are sometimes admitted under one consultant and they are then transferred to another consultant or speciality this will create another episode of care. If this clinical coding is not completed at the point of transfer the episode of care will keep on appearing on the un-coded list in the EPR system

At the point of discharge or transfer the nurse in charge is responsible for ensuring the discharge summary/care plan pathway has been completed at this point all episodes will be coded.

Coding self-harm prior to admission

Patients are often admitted after they have self-harmed. These patients have usually been treated in the acute hospital (UHNM) for the immediate effect of the self-harm and this episode of care will have been coded by the acute hospital.

Therefore when the patient is transferred to Harplands Hospital the consultant in charge of the patient's care will enter a psychiatric diagnosis on the discharge summary and record a history of self-harm. The clinical coder will then code the psychiatric problem(s) followed by other relevant code(s) including history of self-harm.

Self-Harm whilst an in-patient

If the consultant in charge of the patient completes a discharge summary that specifies "self-harm" whilst during the inpatient episode the clinical coder will review the incident form or query with the consultant for clarification, for example:

What type of self-harm? Cut wrist
What did they do it with? Ring pull from drinks can
where did they do it? On the ward

Reference to self harm during the episode of inpatient care must be documented on the discharge summary. Also a psychiatric diagnosis is required. Where episodes of self-harm occur during an episode of home leave this also must be documented on the discharge summary.

Learning Disabilities

Patients who are given a primary diagnosis of "learning disability" will be presumed to have been admitted because of the learning disability and will be coded as such. However, whenever there is any doubt, the clinical coder will seek clarification.

In addition to the primary diagnosis, all relevant secondary diagnoses should be recorded on the discharge summary.

Secondary diagnoses might include for instance; conditions or problems dealt with during the episode of care or conditions which pre-exist in the patient, for example:-

Epilepsy
Diabetes whether insulin or non-insulin dependence
Heart conditions
Chest Infection

Asthma
Downs Syndrome
Paraplegia/Tetraplegia
Infantile Cerebral Palsy

Coding of respite care

When patients are admitted for respite care (holiday relief) to enable carers to have a break and the patient is receiving only the care and attention that would normally be given at home by the carer, the clinical coder will assign the code Z75.5 in the primary position and will be followed by the psychiatric diagnosis and then any other chronic conditions of the patient for example:

Z75.5 Holiday relief
F72.9 Severe Learning Disability without mention of impairment of behaviour

Drug and Alcohol Rehabilitation Codes

If a patient is admitted for a specific therapy for 2 or more conditions the coding should reflect the link between the condition and the therapy e.g. a patient admitted for alcohol and cannabis dependence **with** detox treatment for both should be coded as follows:

F10.2 – "Mental and Behavioural disorders due to use of alcohol - dependence"
Z50.2 -"Alcohol rehabilitation"
F12.2- "Mental and Behavioural disorders due to cannabinoids – dependence"
Z50.3–Drug rehabilitation"

Rehabilitation

If a patient is being transferred from wards **1, 2** and **3** to a **Rehab ward**, an assessment must take place. This information must be documented on the EPR.

5. Clinical Coding Process

Every Monday the clinical coder will run a report from the Trust's EPR System, to show all discharged patients from the previous week for each admitting consultant.

The clinical coder will proceed to check the report against the discharge summaries completed; if any discharge summaries are missing the clinical coder will begin to chase the completion of the missing discharge summary for that particular week.

Using the four step coding process the clinical coder will evaluate all information from the discharge summary and other sources available. Tentative codes will be

allocated using the ICD-10/OPCS4 classifications these are then checked and cross-referenced before the final codes are assigned. The process forms a complete diagnostic and procedural record.

6. Data entry onto the EPR system

The coder will complete the data entry onto the EPR system within the same operation as assigning the code. Thus the FCE is researched, coded and data entered by the same person. A second coder will check each discharge summary against the EPR to validate what has been coded, if any errors are found it will be given back to the original coder for the errors to be amended. This will increase the efficiency of the process by reducing both the incidence of data entry error and the time taken from extraction of data to completion of the process. Once correct the second coder will group the episode of care.

7. Timescales

The clinical coder will work on discharge lists produced each Monday.

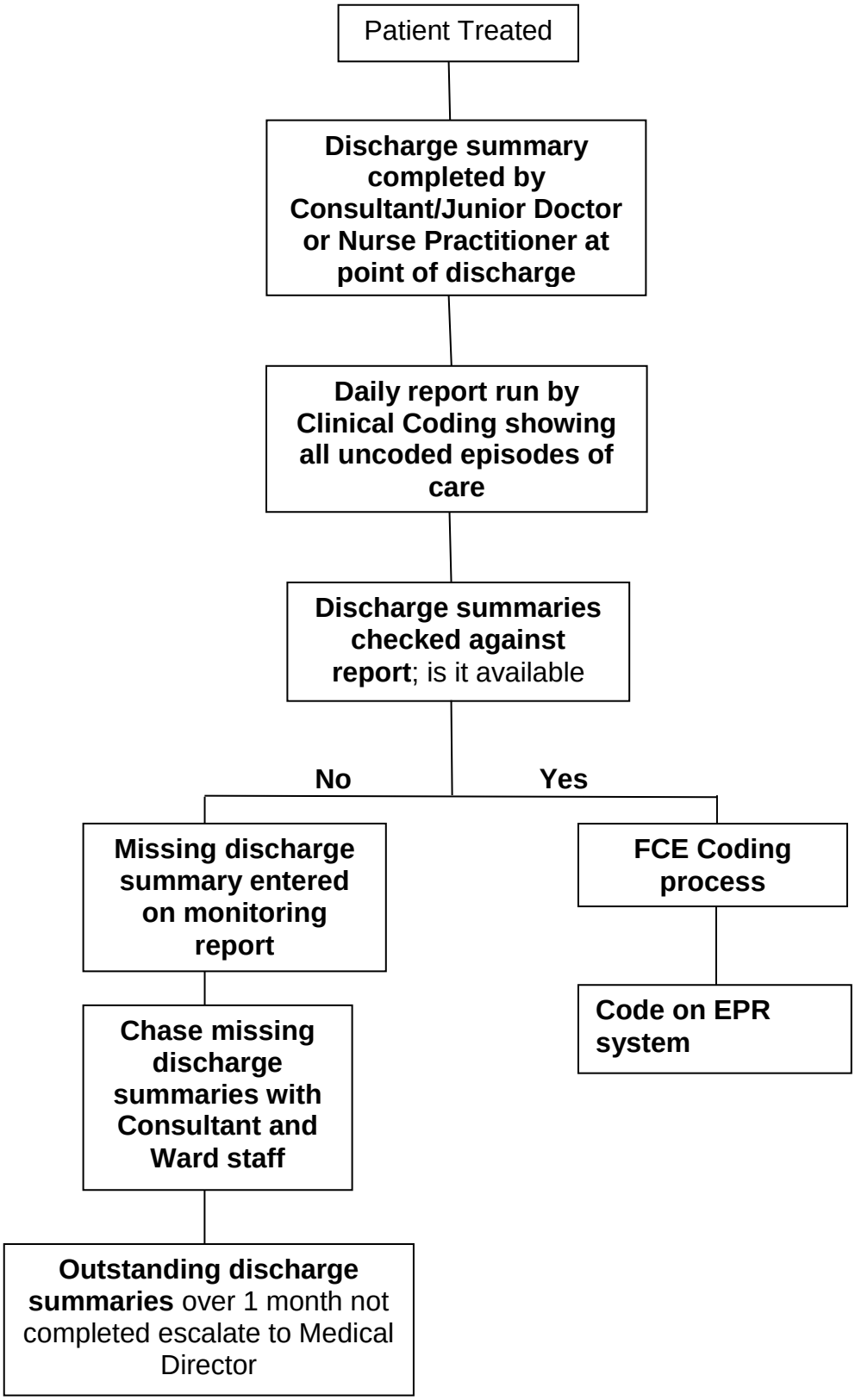
These lists detail FCE's which remain uncoded up to the previous Monday and are referred to as *Missing Lists.* This procedure is designed to discover activity where discharge summaries have not:

- Been completed by the consultant or representative in charge of the patient at the point of discharge, transfer or change of speciality.
- Included sufficient information for coding e.g. (no diagnosis).

The coding assignment closedown date set by the Trust's Performance Team is currently five working days after the last day of the month for the FCE's to be 100% coded.

In order for this to happen the Clinical Coding Team relies on discharge summaries being completed at the point of transfer/discharge with all the diagnosis in full together with all relevant co-morbidities captured for each inpatient episode and recorded in the EPR system so the Coding Department can complete the coding process by the deadline date.

Discharge Summary process



8. Coding Queries

Internal

When a query arises, reference should first be made to all current coding material provided by the Trust. Where this does not provide a satisfactory answer, the query should be directed to the consultant in charge of the patient for clarification.

Helpdesk Queries

When a query is not resolved it may be necessary to refer the query to the Clinical Classifications Service by completing the proforma (before the proforma is submitted it must be escalated to the Medical Director) (Appendix1).

Resolving the query

When the query has been resolved, the result will be circulated to all relevant clinical staff and the clinical coding staff. This will then be evidenced in a comment next to the diagnosis and relate to the source of the information, this could include telephone conversations or emails uploaded onto the EPR system.

9. Retention and Destruction of discharge summaries

Clinical Coding is now completed from reading the discharge summary electronically and entering the codes directly into the EPR. Any communication between the Coder and Clinician will be uploaded into the EPR and a comment will be made against the coding on the screen. The information will remain within the EPR for the life of the record.

10. Validation of Clinical Coded Information

Audit of Completeness

A monthly report will be produced by the Performance Team to validate the inclusion of a primary diagnosis code. Where no diagnosis has been provided or the coding does not apply to the relevant Classification, the consultant in charge of the care will be asked to provide or amend as appropriate. This report will be sent to:

- The Head of Performance and Information
- The Clinical Coding Manager
- The Clinical Coders

An external audit of inpatient clinical coding, based on national standards will be undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor on an annual basis. This is in line with the Information Governance requirement for Clinical Coding. The audits will be co-ordinated by the Clinical Coding Manager.

The results of the audits will be presented to the Executive Director Team and/or Quality Committee.

All audits will be recorded in a central folder held electronically in the Trust's Clinical Coding directory.

Implementing Audit Outcomes

As part of the internal and external audit process an action plan will be developed in partnership with the auditors to implement the required changes as identified within the audit(s). The action plan will be developed and owned by the Chief Information Officer who will be responsible for:

- Accepting the recommendations
- Developing actions to implement the changes
- Assign responsible officers to implement the assigned changes
- Assigning and agreeing action implementation dates
- Liaising with the Performance Department

Monitoring of the action plan will be undertaken by the Chief Information Officer.

Monitoring of the lead officer's progress against assigned actions will be through the regularly scheduled 1-2-1 meetings with their line manager.

Medical Validation

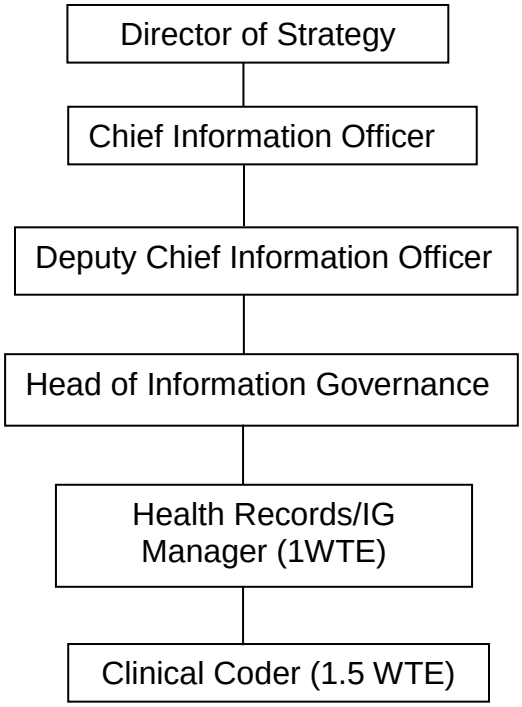
A Consultant Psychiatrist will complete a validation of clinical coding; each month they will audit a small sample to check the coding has been completed accurately.

11. Induction/Training

It is recognised that there is a need for both an induction programme for medical staff and for new staff within the clinical coding team(s). New Clinical Coding staff will be expected to complete the Clinical Coding Foundation Course within 12 months of joining the department; this will be monitored through the personal review process.

Junior Doctors will be provided with EPR training during their induction process.

12. Team Structure



Appendix 1

Terminology and Classifications Delivery Service

CLASSIFICATION / CODING QUERY AND RESOLUTION

Submission Requirements

Clinical coding professional

- Before submitting your query, please follow all steps of the *Clinical Coding Query Mechanism* as you may be able to resolve the issue locally
- Please complete all sections of this form and include supporting anonymised documentation where appropriate.

Other (e.g. data analyst, information / business manager)

- Please complete all sections of this form and if you require codes from earlier editions of ICD-10/OPCS-4, please state this in your submission.

Important information applicable to all query submissions

- Only submit one query per form
- Provide a clear and concise query with as much detail as possible
- If your query is unclear or has insufficient information, it will be returned with a request to resubmit with the missing information
- When submitting your query please indicate in the e-mail subject line which classification it relates to
- Responses are provided for the current edition of ICD-10 and OPCS-4 and reflect the current national clinical coding standards unless otherwise indicated in the question
- All responses are specific to the question asked and may not be transferrable to other scenarios.

Your Details

Name								
Job title								
Clinical coding credentials	**ACC**	☐	**Accredited Trainer**	☐	**Accredited Auditor**	☐	**None**	☐
Organisation name, address and telephone no								
Email address								

Query Details

The classification your query relates to	ICD-10 ☐	OPCS-4 ☐

If your query relates to a previous resolution you have received please provide the reference number	

Name of finding, diagnosis, disorder or condition or name of procedure/ intervention	

Your query

Indicate the outcome/findings from following the Clinical Coding Query Mechanism and give a clear and concise explanation of your query and reason why you are unsure/unable to assign codes following your investigations, including:

- *Your suggested code(s)*
- *Discussions with responsible consultant/coding colleagues*
- *Internet research results*

Have you provided fully anonymised supporting documentation or any other additional documentation?	Yes ☐	No ☐

If not, please explain why

Please email the completed form and supporting information to:
information.standards@nhs.net

Note that queries are received by a first line support service who pass them to the appropriate work area. This query and the resolution you receive from the Terminology and Classifications Delivery Service may be added to the Query Resolution Database. Extracts from supporting documentation will not be included on the database.

For Terminology and Classifications Delivery Service use only

Service Desk reference number:	(PLEASE QUOTE ON ALL CORRESPONDENCE RELATED TO THIS QUERY)
Summary Key Term:	

Important Information

The Terminology and Classifications Delivery Service release the classification standards ICD-10 and OPCS-4 and updates for use across the UK and provide the official national clinical coding standards and guidance for application in the NHS, England.

The resolution below relates to the specific query and information provided by the submitter on the clinical coding query form and should not be considered transferrable across all situations.

Changes to national clinical coding standards are published on an annual basis in the National Clinical Coding Standards reference books for OPCS-4 or ICD-10.

In-year updates to guidance or notification of improvements to the National Clinical Coding Standards reference books for ICD-10 and OPCS-4 are published in the *Coding Clinic*.

Query Resolution

Dear

Thank you for your query.

Terminology and Classifications Delivery Service

If you require further information in relation to this query, please submit a new Clinical Coding Query form, to *information.standards@nhs.net* quoting the Service Desk reference number. On receipt of form the query will be assigned a new Service Desk reference number and progressed.

The query process is available in the Clinical Coding Query Mechanism link at the top of this form.

Appendix 2

Clinical Coding staff training programme

This form contains information regarding training courses clinical coding staff have attended and the dates of attendance.

Name of Coder	Training Course Attended	Date of Attendance
Lorraine Forrester	Mental Health Foundation Course (3 days)	September 2005
Lorraine Forrester	Clinical Coding Foundation Course (over 13 days)	Sept-Dec 2006
Lorraine Forrester	Clinical Coding Mental Health Refresher Course	April 2015
Lorraine Forrester	Coding Training on extracting information from discharge summaries (0.5 day)	29 July 2016
Lorraine Forrester	Clinical Coding ICD 10 & OPCS update course	30 March 2016
Lorraine Forrester	Clinical Coding Mental Health Refresher Course (1 day)	20 August 2020
Brenda Pennington	Mental Health Foundation Course (3days)	November 2008
Brenda Pennington	Clinical Coding Foundation Course (over 18 days)	Apr-Jun 2009
Brenda Pennington	Mental Health Refresher Training	29 September 2009
Brenda Pennington	Rehab Workshop	5 August 2011
Brenda Pennington	New ICD 10 books – Training	26 March 2012
Brenda Pennington	Driving Forward Mental Health Clinical Coding	2 July 2013
Brenda Pennington	Clinical Coding Mental Health Refresher Course	April 2015
Brenda Pennington	Coding Training on extracting information from discharge summaries (0.5 day)	29 July 2015
Brenda Pennington	Clinical Coding ICD 10 & OPCS update course	30 March 2016
Brenda Pennington	Clinical Coding Mental Health Refresher Course (1 day - Microsoft Teams)	20 August 2020
Michael Gater	Clinical coding Foundation Course (Over 21 Days)	Oct–Dec 2019
Michael Gater	Mental health Foundation course (3 days)	24-26 August 2020

North Staffordshire Combined Healthcare NHS Trust

Document level: Trust
Code: 7.13
Issue number: 1___

Data Quality Policy

Lead executive	Executive Director of Finance
Authors details	Head of Information and Data Quality

Type of document	Policy
Target audience	All Trust Staff
Document purpose	This policy sets out the standards for ensuring data quality standards are met and provides all employees with the framework necessary for the assurance of Data Quality in all Trust electronic systems.

Approving meeting	Quality Committee Trust Board	Meeting date	4th February 2021 11th February 2021
Implementation date	12th February 2021	Review date	28th February 2024

Trust documents to be read in conjunction with	

Document change history		Version	Date
What is different?	Revised Policy		
Appendices / electronic forms			
What is the impact of change?			

Training requirements	There are no specific training requirements for this document.

Document consultation	
Directorates	Data Quality Forum
Corporate services	SLT Quality Committee
External agencies	N/A

Financial resource implications	No

External references
1.

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)		
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.		

For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	None

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non				

patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		Date	

Introduction

Data quality is central to the Trust's ongoing ability to meets it's statutory, legal, financial and other contractual requirements. Missing data, duplicate records and broken data can undermine the Trust's ability to work, ensure patient safety and can lead to the loss of income. Poor data quality can also inhibit innovation, research and development.

This document sets out our approach to understand the root causes of data quality problems within the Trust and to put in place processes to support staff to prevent them.

'Data quality is the state of accuracy, completeness, reliability, validity, timeliness and systemic consistency that makes data fit for purpose'[1]

The purpose of the Policy is to:

- Confirm the Trust's commitment to a continual improvement in the quality of its data
- Confirm the Trust's on going 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 policies.

Background

The availability of complete, comprehensive, accurate and timely data is an essential component in the provision of high quality mental health services and risk management. It is also required to ensure compliance with external regulatory requirements and with 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 data quality can create clinical risk, compromise effective decision making and impact on the Trust's ability to monitor standards of care and secure income for its services.

All Trusts submit patient level and aggregated data to external regulators and national and local commissioners, including data sets and performance figures used for local and national monitoring and planning. Consistency and compliance with national standards are therefore essential – Trusts are measured and judged on the data they produce, and assessment ratings depend on good quality data. Commissioning bodies require accurate and timely data from the Trust to monitor service quality and contractual compliance.

An excellent standard of data quality is required to support commissioning through the Clinical Commissioning Groups to ensure positive working relationships through understanding of the services commissioned by the Commissioning Groups underpinned by quality data and information.

Data quality has also been identified as critical to the successful implementation of Service Line Management and Service Line Reporting.

[1] First National Data Quality Review: Quality Information Committee – NHS England

Poor data quality may lead to:

- Poor management decisions within or about the Trust
- Avoidable serious incidents occurring
- Staff and patients being put at risk through invalid or incorrect decisions being made about patient care
- Loss of confidence in the validity of the recorded information
- Adverse assessment from the Care Quality Commission, NHS England/Improvement or NHS Digital
- The inability of the Trust to evidence the quality of care that is provided and incorrect data published locally or nationally
- Loss of income to the Trust
- The Trust being compromised in achieving the requirements set out in the Information Governance Toolkit

It is therefore essential that we achieve a state of accuracy, completeness, reliability, validity, timeliness and systemic consistency that makes data fit for purpose.

Francis Report

Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust was published in February 2013. At the heart of the failure identified was a lack of openness, transparency and candour in the information emanating from the Trust and over-reliance on that information by others.

Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care.

There is an imperative to create a culture and understanding in staff of the value of capturing high quality data in real time to improve patient care. All members of staff are required to continually record accurate data to ensure high quality care to all patients and stakeholders.

Continuous process of improvement

The activity and functions within NSCHT are dynamic and changing. In March 2017 the Trust's Substance Misuse inpatient services moved to Halo and in May 2017 the Trust moved to a new Electronic Patient Record, Lorenzo. These changes place a significant data quality challenge as new business processes and data entry requirement are embedded.

Even where the processes do not change the quality of data can change due to human intervention, system failure and misunderstanding. Therefore, there needs to be a continuous process to monitor data quality to identify and correct data quality issues. Ensuring data quality is not a project with an end.

Defining Data Quality

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

Data Quality Principles: 'Figures you can Trust'

The Audit Commission provided 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 still relevant and included in the table below:

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.

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, contacts and interventions must all be recorded. Data must be recorded by Social Service staff where they work in integrated teams with Mental Health staff. Correct procedures are essential to ensure complete data capture. Spot checks, exception reports and audits will be used to identify missing data.
Accuracy	Data recorded on computer systems must accurately 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 within reasonable timescales of publication. Every opportunity will 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 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. All data must be recorded within specified deadlines; data entry must take place according to Trust policy. This will ensure that up to date data can be included in national, local and internal reports.

Data Model & Data Dictionary

NHS data standards are developed by the Data Services team within the Department of Health's NHS Digital. Examples of data standards include the International Classification of Diseases database and the NHS Data Model and Dictionary.

The NHS Data Model and Dictionary provides a reference point for approved Information Standards and Collections (including Extractions) to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS.

The Data Protection Act (DPA) controls how organisations, businesses or the government uses personal information. Everyone responsible for using data has to follow strict rules called 'data protection principles'.

Information Governance

Information Governance provides the Trust with a consistent way of dealing with all the requirements of information handling.

The following table details the requirements within the Data Security & Protection Toolkit in Standard 1.7 that directly relate to data quality.

Monitoring through the requirements of the Toolkit will continue throughout a period with any gaps in assurance rectified through the implementation of an action plan agreed between the Requirement Lead and the Information Governance Lead.

Measure	Reference	Description
1.7 Effective Data Quality controls are in place	1.7.1	Intentionally left blank
	1.7.2	Data quality metrics and reports are used to assess and improve data quality.
	1.7.3	A data quality forum monitors the effectiveness of data quality assurance processes.
	1.7.4	Has a records retention schedule been produced?
	1.7.5	Provide details of when personal data disposal contracts were last reviewed/updated.
	1.7.6	Intentionally blank, old evidence item

Scope

The principles outlined in this policy are applicable to all corporate information that is entered onto a computerised system whether centrally or locally maintained.

Whilst the main emphasis is on the Trust's main EPR, Lorenzo and in the supporting Business Intelligence reporting, all Trust computerised systems are included

Summary details of the Trust's electronic information systems are set out below:

Trust Electronic Information Systems:

System	Types of Service using the System	Scope of system
Lorenzo	All Trust services with the exception of Substance Misuse services and Psychological Therapies in Primary Care	Primary electronic health care record.
Business Intelligence (BI)	All Trust services using Lorenzo	Bespoke reporting system providing operational management and summary performance reports from Lorenzo
Nebula	Substance Misuse Services	System used to capture activity for the Trust's inpatient and Stoke Community Substance Misuse Services
Halo	Substance Misuse Services	System used to capture activity for the Trust's Stoke Community Substance Misuse Services
IAPTUS	Psychological Therapies in Primary Care	IAPTUS is a web based system used to capture activity for the Trust's Psychological Therapies in Primary Care services
Integra	All services within the Trust	The general ledger is a fully integrated financial administration and management system incorporating Invoice processing (income and payments), purchase order processing and general ledger transaction processing (Journals and Budget updates).
Patient Level Costing System (PLICs)	All services within the Trust	Analyses cost by Service Line to Patient Level, as well as detail of the activities associated with the care provided.
Safeguard	All staff reporting clinical and nonclinical incidents, Risk assessors and managers and the Patient Experience Team	Risk Management system capturing and managing all Trust patient safety data within one system including risk, complaints and incident related themes and trends.

ESR	HR & Payroll	Electronic Staff Record (ESR) is a national HR/Payroll system that has been designed and developed to be the comprehensive, integrated workforce management system which will deliver the workforce strategy for the NHS.
MAPS Health Suite – e-Rostering and e-Expenses	All staff required to eRoster shifts	eRostering is an electronic way of efficiently managing when staff are required for work.
LMS	Learning Management System - All employees, volunteers and students access the LMS	The LMS is now being used to deliver, record and report on e-learning for all staff, enabling e-learning sessions and assessments, as well as ad-hoc training.
TRAC	All Managers and key staff required to recruit new employees.	TRAC manages the recruitment process from advertising, shortlisting, interviews, offer letters and employment checks through to the candidates' start date and induction.

The scope of this policy primarily covers the data quality standards applicable to the collection, processing and exchange of data relating to clinical service delivery.

This policy is intended to cover all service user information that is recorded within the Trust. The principle emphasis of the policy is on the Lorenzo system, the documents used to feed the system, the related processes e.g. new users, and the data extracted from it.

Data Quality Principles

Operational

Business strategy drives the context for any data quality strategy. The aim is to improve the quality of key data assets to support decision-making and provide clinical insights. Where possible data quality issues need to be resolved at source to avoid expensive retrospective validation/data cleansing processes.

Establishing an expectation that everyone contributes to continuous in data quality requires leadership, drive, time and resource. Integrating and aligning the responsibility of data quality to budget holders will help to establish it as a business as usual activity.

Ownership and accountability for systems and functions rests with the business/ data owners of the source data.

Often data quality issues can perpetuate. By securing the time and resource to identify and fixing the root causes we can stop their recurrence at an early stage.

Strategic

Not all data quality issues can be resolved at an operational level or even be recognised. Data quality issues can arise between systems and functions (e.g. operations and finance) and these integration issues need to be explicitly addressed by the Trust's Data Quality Forum.

Consistency can be established through the agreement of definitions and Trust-wide policies and standards.

Governance

The purpose of data quality governance is to improve and maintain the data quality. Clinical Directors and Operational Associate Directors empower service managers and service managers empower staff. Operational Associate Directors should be held responsible for data quality and they need to be provided with the support and resources to ensure success.

Ultimately the Board is accountable for the Trust's data quality and it gains its assurance through the lead Executive and the data management processes established for improving data quality.

Structure

The Trust has a clear management structure clarifies the responsibilities and accountabilities in regard to those individuals who enter in data. This ensures that there is accountability for low levels of data quality and accuracy.

Duties

The recording of good data quality 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.

The following duties apply to this policy:

Trust Board

Trust Board, through their scrutiny of the content of the Trust Board's Improving Quality & Performance Report (IQPR) monitor clinical services performance against set data quality standards and are in a position to request corrective action be taken where this is deemed necessary.

Executive Directors

The Executive Directors are responsible for:

- Ensuring data quality requirements are embedded within the Trust's processes, including staff induction and job descriptions
- Ensuring corrective action is taken where this is required.

Executive Director of Finance/ Associate Director of Performance

The Director of Finance, through the Associate Director of Performance, is responsible for:

- Ensuring that appropriate data quality performance monitoring reports are available to Trust Board, Clinical Directors, Associate Directors, managers and clinical leads
- Ensuring appropriate risk assessment mechanisms are in place in the Trust to identify where data quality improvement action may be required

Clinical Directors and Associate Directors

The Clinical Directors and Associate Directors are responsible for:

- Incorporating data quality requirements within the annual service plans
- Monitoring and addressing data quality issues within their clinical services
- Monitoring timeliness of data entry

Staff

All staff are responsible for ensuring adherence to the relevant data standards and for ensuring good data quality.

Clinical Staff

Clinical staff is responsible for:

- Ensuring timely, accurate and complete input of their own clinical data.
- Regularly checking service user data with service users, updating any inaccuracies and recording data that previously has been missing.
- Monitor and address any data quality issues, escalating if appropriate
- Be aware of and comply with legislation and Trust policies and procedures in respect of data entry and accuracy
- Be fully conversant with and remain proficient in the use of all trust information systems pertaining to their roles

Clinical Services and Administration Managers

Clinical Services and Administration Managers are responsible for:

- Ensuring that all staff input accurate and complete data in a timely manner
- Ensuring that all staff are aware of their responsibilities with regard to checking and updating any inaccuracies and missing data items in service user demographic data
- Addressing any data quality issues as soon as possible and escalate appropriately
- Ensuring that all procedures are documented, updated regularly, and available to all staff
- Ensuring that all staff are familiar with and adhere to current legislation, policies and procedures
- Monitoring staff competencies and training needs and ensure that staff attends appropriate training. Where required clinical system training, including refresher training, should be included in the PDR process.

Clinical coding staff

Clinical coding staff are responsible for:

- Ensuring coding of inpatient clinical data is accurate, complete, and timely.
- Using the standards set out in the NHS Clinical Coding Instruction Manual (Substance Misuse services adhere to the standards required for reporting to the National Treatment Agency (NTA) in the NDTMS data set submissions.
- Ensuring all coding is carried out from an auditable source document
- Maintaining a record of any diagnosis or procedure queries raised with clinicians, including outcome of the discussions
- Ensuring they have access and are proficient to source systems which enable them to accurately record the diagnosis and co-morbidities

Performance and Information

Performance and Information staff is responsible for:

- Interpreting requirements of the Data Dictionary and Data Manual and ensure compliance of all Trust data
- Ensuring that all systems support robust data collection
- Liaising with system suppliers with respect to updates of system-wide reference files
- Producing or enabling production of exception reporting to monitor data quality
- Acting appropriately on any data quality issues in a timely manner
- Being aware of and complying with legislation and Trust policies and procedures
- Working in partnership with clinical services to improve data quality
- Working in partnership with clinical services to improve data quality
- Developing Key Performance Indicators (KPIs) monitoring data quality
- Incorporating data quality KPIs within the performance reporting framework
- Completing an annual completeness and validity check as described within the Information Governance Toolkit

Data Quality Forum - Data issue management

The Data Quality Forum is responsible for data issue management, the process of reducing and removing the barriers that limit the effective use of data within the Trust. This includes identifying DQ issues, approving definitions, establishing quantification of issues, prioritizing DQ problems, tracking progress, reporting to the Finance & Resource Committee and the Board and ultimately resolving the DQ issues.

The Forum will oversee and monitor progress against an annual Data Quality Work plan designed to resolve and manage key data quality issues identified as a priority at the start of each year.

The Forum also ensures a high standard of data quality within the clinical systems across NSCHT and recommend to other appropriate forums changes that need to be made to systems or processes to deliver improvements in data quality

The Data Quality Forum will be concerned with policy development and compliance at the right level of granularity to make a difference. Reporting and monitoring are key components of data quality management. In addition, the Forum will ensure that staff are aware of their responsibilities surrounding excellent standards of data quality through continuous communication and promotion

Data Quality Metrics

To make the governance process manageable and monitoring proportionate, appropriate key data quality metrics need to be developed and kept in review to support the governance arrangements. This will be discharged through the review of business processes; identification of critical data flows; analysing (potential and actual) data quality issues; defining key data quality performance measures; and agreeing tolerances thresholds (beyond which issue are escalated).

Demographic Data

Demographic data provides the essential building block for the Trust's collection of clinical information. Maintaining the highest possible data quality for this data is crucial to the Trust's functioning.

Demographic data covers all personal data belonging to the service user including, but not limited to,

- Name
- NHS Number
- Date of Birth
- Address
- Ethnicity
- Marital Status
- Registered GP Practice
- Next of Kin
- Responsible Clinical Commissioning Group
- Sexual Orientation

Items such as NHS Number and Date of Birth are essential to ensure that service users are identified correctly. Other items such as Ethnicity enable the Trust to monitor its service provision and ensure that service users of all ethnic backgrounds receive equality of service.

Staff is responsible for checking demographic details with service users at all attendances. Where changes are identified they must 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.

A number of key demographic data items are externally performance managed, through submissions of the Mental Health Minimum Data Set (MHMDS). Data quality of the core MHMDS data items, and for Substance Misuse services data quality in the NDTMS core data set, is internally performance managed through the Trust's performance reports.

Regular audits will additionally check the quality of these data items so it is vital that all demographic data is recorded accurately, completely and kept as up-to-date as possible.

NHS number and duplicates

Staff must encourage service users to provide their NHS number where it is not already known.

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.

Having a duplicate paper or electronic record presents a high risk to service users and staff. Every effort should be made by staff to identify and eliminate duplicates and to avoid any sort of paper records. Rigorous application of the correct registration procedure for new service users on Lorenzo and other systems is key to reducing duplicate records.

If duplicate records are identified by a staff member on the Lorenzo system, the patient details of the record, must be recorded on the IT Service Desk (available at http://nww.itservicedesk.northstaffs.nhs.uk/) so that they can be checked and merged by the appropriate IT staff ensuring that an audit record is created to record the merge and change.

Validation of Data Quality

Audit of Completeness / Validity

On a regular basis, data quality checks will be run against specified data items within the Lorenzo system and other Trust systems to check for completeness, consistency and accuracy. The data items checked may vary in accordance with the Trust's priorities and will also expand over time.

Identifying and correcting errors and omissions

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

Where standard reports are available from systems for use by clinical, managerial and administrative staff, these must be used to check for inaccurate, incomplete or untimely data.

Recipients of scheduled daily, weekly or monthly information must check all reports for inconsistency of information or missing data. All errors and anomalies must be reported to Performance and Information staff for investigation and corrective action taken as soon as possible.

The appropriate department or individual/service must investigate queries, gaps in data items, and anomalies raised by Performance and Information staff as a result of report production. Errors and omissions must be corrected within agreed timescales.

External data quality reports, will be checked by Performance and Information staff and any issues addressed before the next return deadline.

Training

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 are appropriate to their role. Data Quality can be a dry subject and staff need support. The design of practical training will raise awareness and can help to develop good data quality routines.

Access to systems will not be granted until the appropriate training has been completed. Existing staff must have access to on-going 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.

These Procedures and Quick Reference Guides (QRG's) are maintained by the Clinical Systems team to support Staff and are available on the Trust Intranet. Additional support at a Service level is provided by a network of Super Users and Digital Champions.

National Tools to support Data Quality

Data Quality Maturity Index (DQMI)

The DQMI is a monthly publication intended to raise the profile and significance of data quality in the NHS by providing data submitters with timely and transparent information about their data quality.
DQMI is currently based on the completeness, validity, default values and Coverage of the core data items agreed by the National Information Board (NIB) working group. Fields or data items include NHS number, date of birth, gender, postcode, speciality and consultant.

DQMI currently includes the following national submissions :

- Accident and Emergency (Includes A&E (type 010) and ECDS (Type 011) data)
- Admitted Patient Care
- Community Services
- Emergency Care Dataset (Excludes A&E (type 010) data)
- Improving Access to Psychological Therapies
- Maternity Services
- Mental Health Services
- Outpatient

For Substance Misuse Services there is the National Drug Treatment Monitoring System (NDTMS) Adult drug and alcohol treatment business definitions Core dataset N.

Data Quality Assurance Framework

The Provider Data Quality Assurance Framework was developed by NHS Digital and is aimed at provider organisations who, in terms of data quality assurance, need to get started and those that are looking to build on their existing data quality assurance processes and practices.

The framework has been developed to meet the requirements of Assertion 1.7 of the Data Security & Protection tool

The framework covers five main themes:

- oversight
- process
- people
- systems
- measures

Within each section describes its objective, the benefits associate with it and current best practice.

Each part of the framework also includes an Assurance Checklist to assist provider organisations assess where they are in terms of data quality assurance and what gaps there might be that the framework can help fill.
The Trust will continue to monitor changes to the Data Quality Assurance Framework and adapt policy to ensure alignment with the latest best practice in Data Quality Assurance.

Electronic Staff Record Data Quality Reports (WOVEN)

The Workforce Validation Engine (WOVEN) is a monthly data quality report on data in the Electronic Staff Record (ESR). This is sent to individual organisations, allowing them to correct their data at source. It also provides national rankings for data quality scores against an agreed list of criteria.

SUS Data Quality Dashboards

SUS Data Quality Dashboards (DQDs) report on SUS data via a user-friendly dashboard interface, allowing registered SUS users to:

Monitor improvement and completeness for a number of key fields from the patient record over the different commissioning data sets (CDS).

- Assess sender organisation data in SUS to ensure completeness and compliance with data standards.
- Compare sender organisation to national and regional level data.

Monitoring policy compliance and effectiveness

Performance

Data quality KPI's form part of the Performance reports provided to Trust Board, Executive Management Team and Directorates. These reports also identify the improvement in data quality over time and where further data quality improvements are still required.

These reports must be used by managers to monitor the timeliness of data entry for the staff under their management. Where a staff member's performance does not meet the expectations laid out within this policy the manager should take appropriate action to ensure improvement. This will include refresher training on the use of the clinical system, performance management and, in extreme cases, disciplinary action.

Review and revision arrangements

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

Related Policies

The Data quality policy links to the following related policies:

- Lorenzo EPR Policy, SOPs and Quick Reference Guides
- Confidentiality of patient and Employee Personal Information Policy
- Access to health & Employee Records Policy
- Information Security & Data Protection Policy
- Staffordshire Information Exchange Policy
- Information Governance Policy
- Clinical Coding Policy and Procedures
- Policy and guidelines on the management of Ethnic Information
- Implementing the Mental health Minimum Data Set Policy
- Halo Supporting Guidance Document for the Edward Myers Inpatient
- Halo Supporting Guidance Document for the Edward Myers Intoxicated Observation Unit (IOU)