Mid Essex Hospital Services NHS
NHS Trust

Data Quality Audit Policy	**Type:** **Register No: 07021** **Status: Public**

Developed in response to:	Information Governance Toolkit requirement 506 Audit Recommendations Identified financial and clinical risk
Contributes to CQC outcome:	21

Consulted With	**Post/Committee/Group**	**Date**
Eileen Hatley	Data Quality Manager	19th March 2018
Ian Harrison	Head of Information Services	19th March 2018
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Professionally Approved By	Chief Information Officer	19th March 2018

Version Number	7.0
Issuing Directorate	Informatics
Ratified by:	DRAG Chairman's Action
Ratified on:	10th April 2018
Executive Management Group Sign Off	June 2018
Implementation Date	8th June 2018
Next Review Date	March 2021
Author/Contact for Information	Caroline Holmes
Policy to be followed by (target staff)	All staff with responsibility for Data Input on PAS
Distribution Method	Intranet & Website
Related Trust Policies (to be read in conjunction with)	Data Quality Policy (06019) Data Quality Strategy (11072)

Document Review History:

Version No:	**Reviewed by:**	**Issue Date:**
2.0	Richard Chapman	May 2011
3.0	Caroline Holmes	January 2012
4.0	Caroline Holmes	February 2013
5.0	Caroline Holmes	February 2014
5.1	Caroline Holmes - minor change Section 5	17th March 2015
6.0	Caroline Holmes	1st March 2017
7.0	Caroline Holmes	8th June 2018

Contents

1.0 Purpose

1.1 The purpose of this policy is to ensure the Trust can demonstrate it is maintaining high quality information about its service users. Good quality information supports the Trust internally in the delivery of care, operational and strategic management and overall governance, as well as externally for accountability, commissioning and strategic planning purposes.

1.2 High quality data is defined for this purpose as:

- accurate
- up-to-date
- free from duplication
- free from confusion

2.0 Lorenzo Transition Period

2.1 The Trust implemented a new Electronic Patient Record system (Lorenzo) at the end of May 2017. The Data Quality Team was heavily involved in the data migration process, the cutover process from PAS to Lorenzo and in supporting users in the accurate recording of information. Since go-live the Data Quality Team have been spent a number of months rectifying data errors on the system that have been identified from operational reports, national data returns and internally identified issues.

2.2 Consequently the Data Quality Team has not been in a position during 2017/18 to fully comply with the Information Governance Toolkit Requirement 506.

2.3 50% of the recommended audit sample size will be carried out for 2017/18.

2.4 The Trust plans to achieve 100% compliance with the recommended audit sample size for 2017/18 and beyond.

2.5 The remainder of this policy is written as though 50% coverage will be met.

3.0 Aims

3.1 To ensure data relating to central returns or is submitted to the Secondary User Service (SUS) and Hospital Episode Statistics (HES) is of high quality.

3.2 The audit is to provide assurance as to the accuracy of data recorded on Lorenzo. This is the primary source of data for SUS, HES and central returns.

3.3 Failure to ensure data is of sufficiently high quality may result in avoidable clinical, financial and legal risks being incurred by the Trust.

3.4 The Trust has a legal duty to ensure that the data it records is timely, accurate and up-to-date, in line with the Fourth Principle of the Data Protection Act 1998 (to be superseded by General Data Protection Regulation (GDPR) on 25th May 2018).

3.5 The Trust has an ethical duty to its staff and patients to ensure that data recorded in all records is timely, accurate and fit for the purpose for which it is intended.

4.0 Scope

4.1 This policy is intended to cover all data entered onto the Lorenzo (the Trusts Electronic Patient Record system) that is submitted to SUS covering 4 data sets:

- Admitted Patient Care
- Critical Care Minimum Data Set
- Elective Admission List
- Outpatient Data

4.2 The policy is limited to activity recorded on Lorenzo that is sent to SUS and does not include any other electronic system holding data or any activity not submitted to SUS.

5.0 Responsibilities

5.1 **Chief Executive:** Ultimate responsibility for data quality lies with the Chief Executive.

5.2 **Trust SIRO (Serious Incident Reporting Officer):** Day to day responsibility is delegated to the Trust SIRO.

5.3 **Head of Coding, Records and Data Quality:** Responsible for reporting the findings of the Audit to the Information Governance Group and completing an action plan as necessary.

5.4 **Data Quality Team**: Responsible for ensuring the day to day accuracy of data recorded on Lorenzo and for overseeing the audit process. They also act as second accuracy checker.

5.5 **All users of Lorenzo**: Responsible for inputting data correctly onto Lorenzo that accurately reflects the patients care pathway.

5.6 **Information Governance Group:** Responsible for ensuring compliance with the Policy and for escalating any appropriate issues to the Patient Safety and Quality Group.

5.7 **Information Services Team:** Responsible for completing central returns and submitting SUS data in line with national timescale. They are also responsible for selecting the random data sample for audit.

6.0 Sample Size

6.1 The minimum sample size for the audit is outlined in the 'IG Toolkit Version 14 Secondary Uses Assurance Requirement 14.1-506 Key Data Items List' and varies depending on the data set being audited. For 2017/18 the sample size for each data item is:

6.2 Admitted Patient Care

6.2.1 The sample size must be 0.5% of a Trust's total annual Finished Consultant Episodes (FCE).

6.2.2 The sample size is taken from the total of FCE for the previous financial year e.g. 2016/17. 0.25% of this total provides the sample size.

e.g. 109,367 * 0.25% = 273

6.2.3 The minimum sample size the Trust must undertake for the year is 273.

6.3 Critical Care Minimum Dataset

6.3.1 The sample size must be 0.25% of a Trust's total annual Critical Care Minimum Dataset.

6.3.2 The sample size is taken from the total of Critical Care for the previous financial year e.g. 2016/17. 0.25% of this total provides the sample size.

e.g. 1,362 * 0.25% = 34

6.3.3 The minimum sample size the Trust must undertake for the year is 34.

6.4 Elective Admission List

6.4.1 The sample size must be 2.5% of the Trust's planned end of year waiting list census.

6.4.2 The planned end of year waiting list is 9,997

e.g. 9,997 2.5% = 249

6.4.3 The minimum sample size the Trust must undertake for the year is 249.

6.5 Outpatients

6.5.1 The sample size is taken from the total of attendance for the previous financial year e.g. 2016/17. 0.1% of this total provides the sample size.

e.g. 516,973 * 0.1% = 516

6.5.2 The minimum sample size the Trust must undertake for the year is 516.

7.0 Method

7.1 The majority of the SUS data items validated will be compared to information contained in the patients' case notes. The use of the terms "case notes" can be taken to mean any other source of confirmation, including electronic (e.g. nursing notes on electronic systems or diagnostics / A&E systems) and manual (e.g. TCI cards).

7.2 The patient's demographic information from SUS will be validated using Summary Care Records (SCR – the electronic database of NHS demographic details) and NHAIS (National Health Applications and Infrastructure Services previously the Exeter System).

7.3 At the request of the Data Quality Manager, the Information Services Team will supply a database of the required data fields from SUS. All fields contained within the file will be as per the National Data Dictionary Definitions. In addition, the case note location as recorded on Lorenzo will be included in the download to assist in finding the notes.

7.4 The database will include the ability for the accuracy checking team to re-key the information for the required data items. This information will then be checked against the SUS information and any errors will be verified by a second accuracy checker.

7.5 The second accuracy checker will be a member of the Trusts Data Quality Team.

7.6 Any errors identified will be recorded in the comments field in the database and will be amended on Lorenzo as necessary. If Lorenzo is updated, appropriate paperwork will be completed as per the Trusts Data Quality Policy. Any amendments required to case notes for demographic data items will be referred to the Medical Records Manager to action.

7.7 To make the auditing process as efficient as possible the data sample will target areas with high volumes of notes in one place to select the case-notes from e.g. Clinical Coding, Medical Records Library.

7.8 If the case-notes for the patient cannot be located or are not available for audit (e.g. patient is a current inpatient, attending a clinic or the notes are mis-filed) this must be recorded in the 'Comments' column.

7.9 Once the correct sample size has been audited the Data Quality Manager is responsible for analysing the results and producing an audit report.

7.10 The Data Quality Manager will complete an action plan as necessary. This action plan and the audit report will be presented to the Information Governance Group for consideration.

8.0 Scoring

8.1 If the field on the Lorenzo is exactly the same as the field in the case-notes, an accuracy score of 1 is recorded.

8.2 If the field on the Lorenzo is not exactly the same as the field in the case-notes, an accuracy score of 0 is recorded.

8.3 If the data is missing from a field on either the Lorenzo or in the case-notes, an accuracy score of 0 must be given.

8.4 The suggested data items to be audited are in the Key Data Items List (see Appendix A). Where the data item is not recorded in the patient's case notes or it is not easily accessible on an electronic system the whole data item has been excluded from the audit (see section 9).

8.5

Sample Area	Sample Size (a)	Number of Fields Checked (b)	Total Possible Accuracy Score (a)*(b)	Pass Score
Admitted Patient Care	273	23	6,279	80%
Critical Care	34	3	102	80%
Elective Waiting List	249	19	4,731	80%
Outpatients	516	18	9,288	80%

Table 1: Details of possible accuracy scoring

9.0 Exclusions

9.1 The SUS submission includes a number of specialties that are recorded on Lorenzo for waiting time monitoring purposes only i.e. diagnostics and interventional radiology. These specialties are excluded from the audit process as the information for billing, clinical audits and recording clinical information is held on other electronic systems.

9.2 The SUS submission includes activity not recorded on Lorenzo where the activity is undertaken at Satellite Units i.e. Plastic Surgery at Colchester Hospital University NHS Foundation Trust and Southend University Hospital NHS Foundation Trust. This activity is excluded from the audit process as the case notes are not readily available to MEHT.

9.3 **NHS Number Status Indicator** - This is not recorded within patient case notes, so has therefore this field is excluded from the accuracy checks. The Information Service Department undertakes regular batch tracing on NHS Numbers to ensure validity and accuracy of this data item on Lorenzo.

9.4 **Referrer Code** – Validating this data field is extremely time consuming as the referring GP is frequently not the GP the patient is registered with (i.e. locum or other member of the practice). The time spent on validating this information is not in line with the need for the data item to be accurate.

9.5 **Primary and Secondary Diagnosis** - Clinical Coding information is audited regularly by both internal and external organisations. Therefore these fields are excluded from the Data Quality Audit.

9.6 **Primary and Secondary Procedures** - Clinical Coding information is audited regularly by both internal and external organisations. Therefore these fields are excluded from the Data Quality Audit.

9.7 **Healthcare Resource Group** - This is not recorded within patient case notes so has therefore this field is excluded from the accuracy checks.

10.0 Discretionary Data Items

10.1 The Trust will adopt the principle outlined in the Information Governance Toolkit 506 that:

'the accuracy check is looking for major discrepancies and errors. It is not concerned with minor differences of interpretation. For instance, if a check of the health record reveals that a service user was admitted as an emergency, then recording of an elective code in the data would definitely be inaccurate. If however, it is unclear in the notes as to the exact method of emergency admission (such as between GP and Bed Bureau), then the assessor may exercise some limited discretion.'

10.2 Where the data item is not specifically recorded in the health record the accuracy checker has the option of using judgement. For example, some records, particularly for outpatients, may contain data items appertaining to events that occurred several years ago, such as Referral Request Received Date for an Outpatient Referral that could be several years old, with no date stamp on the referral letter. In each such case the checker will need to exercise judgement as to whether the record should be excluded from the accuracy calculation for that data item.

11.0 Implementation and Communication

11.1 Corporate Services will ensure the policy is uploaded to the intranet and website and notified to all staff in Focus.

11.2 The Head of Clinical Coding and Data Quality will communicate the policy by email to key departments and individuals.

12.0 Equality and Diversity

12.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

13.0 References

- Audit Committee Terms of Reference
- Information Governance Toolkit, Version 14.1
- IG Toolkit Version 11 Secondary Uses Assurance Requirement 14.1-506 Key Data Items List'
- General Data Protection Regulation - https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/