Data quality good practice: information sheet

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This summary lists good practice data quality policies and procedures gathered through experience of working with a wide range of acute and community provider organisations.

1. Data quality strategy/policy

Have a clear, concise organisation-wide data quality policy or strategy so that all staff understand its contents and the part they play in implementing it.

The policy will set out what the organisation does each day, week, month and quarter to improve data quality and who carries out each task.

It should try to answer the question ‘How can the board be assured about the data being reported – internally and externally?’ It should include the requirement to provide regular reports to the trust board to ensure visibility and assurance of data quality issues. It should also provide a trend analysis of a number of pathways each month.

2. Data quality dashboard

Have a data quality dashboard with no more than five key indicators. These should reflect local priorities and be directly linked to the organisation’s areas of risk. They will therefore vary from one organisation to another. The indicators should be available at specialty and subspecialty level if appropriate.

Common examples are:

- missing/incomplete clinic outcome codes by specialty/clinician
- incompatible codes, for example clinic outcome code of discharge to GP and patient administration system (PAS) code of add to waiting list; clinic outcome code of active monitoring and PAS code of patient ‘did not attend’ (DNA).

3. Data quality checks

Data quality checks should highlight and assure the quality of referral to treatment (RTT) data, including:

- missing outcomes
- obviously incorrect outcomes
- data and data completeness
- delays in clinic letter typing.

Good practice would extend this to standards for un-outcomed attendances and monitoring these standards as part of weekly patient tracking list (PTL)/business/service meetings, and to capture most of the outcomes (for example 90%) on the day of the attendance and 100% within five days of attendance.

Internal data quality checks should include highlighting and assuring the quality of cancer data before it is submitted to Open Exeter.

4. Audit

Organisations should instigate a regular rolling audit programme of RTT data. This should rotate through the organisation’s specialties and extend across the admitted stops, non-admitted stops and the month-end list of incomplete pathways.

Best practice would be for the audit to sample 10% of admitted clock stops, 5% of non-admitted clock stops and corresponding proportions of the incompletes list (10% of the admitted incomplete and 5% of the non-admitted incomplete lists). The audits should be representative of the distribution of waits, so should include waits of 0-1 weeks, 1-2 weeks, 2-3 weeks, and so on, and not focus on clock stops or incomplete pathways over 18 weeks.

Providers should have similar processes to audit cancer pathways to assure their quality.

The results of these regular audits need to inform the organisation’s programme of data quality improvement to target areas of poor data capture and/or inaccurate recording.

There must be a clear feedback mechanism to correct any systemic failures and recognise improvements. Areas of concern should feature on the data quality dashboard and where appropriate be escalated to the organisation’s risk register to ensure visibility.

5. Clear lines of responsibility

If audit results illustrate inaccurate or incomplete recording in a particular specialty, it should be clear either through the data quality policy or through a standard operating procedure, whose is responsible for acting on this information.

This may be through a central team, operational managers in the specialties or a combination of the two. Whichever it is, the responsibility for correcting data, training staff or altering recording methods needs to be clear.

6. Validation

Validation of RTT data is common to all providers. Most organisations fund staff whose sole purpose is to validate RTT data. Turnover of this staff is often high and increases when the posts are temporary. Substantive funding minimises the risk of high turnover and recognises that improving data quality is a continuous process.
7. Frequency of validation

The work to validate RTT data should not be a monthly task. Validation, correction and improvements to data quality need to be done weekly, or ideally, daily.

Because performance is judged on the monthly data it is inevitable that the monthly submissions receive greater attention.

To assess what extra improvements are made through month end validation, organisations can compare the weekly data submissions (volumes of patients approaching 18 weeks, the numbers waiting over 40 weeks and the clock stop activity) to monthly data. Where the gap is large it suggests the organisation relies too much on month-end processes that are under greater time pressures and present a risk to the reported performance. Spreading the validation effort across the entire month minimises this risk.

8. Importance of patient tracking list availability

It would be best practice to refresh the PTL every day, but having it available at least twice a week will enhance timely patient pathway management. The PTL should provide clear visibility of cancer patients, as well as elective and planned patients, to support engagement and timely patient management.

Data quality checks should be incorporated as part of good patient pathway management (for example, duplicate referral check at registration, pathway validation at decision to admit). The PTL should also be structured to highlight data quality/completeness issues.

9. Submissions

Have a nominated executive and deputy, responsible for the sign-off of RTT and cancer returns, before submission.