Information Quality Improvement (IQI) Working Group Minutes

Date: 21 May 2019 **Time: 13:00–16:00**

Venue: NWIS Cardiff Board Room, 1st floor, Ty Glan Yr Afon, 21 Cowbridge Road East, Cardiff. CF11 9AD.

Helen Thomas (HT) Chair	NWIS
Daniel Hughes (DH)	NWIS
Sian Davies (SD)	NWIS
Sarah Taylor (ST)	NWIS
Paul Mason (PM)	NWIS
Rebecca Cook (RC)	NWIS
Dilwyn Bull (DB)	Aneurin Bevan
Richard Westwood (RW)	BCU
Beverley Cartwright	BCU
Trevor Davies (TD)	Powys Teaching HB
Michelle Williams (MW)	Powys Teaching HB
Graham Crooks (GC)	Cwm Taf
Bethan Davies (BD)	Velindre
Raul Garcia (RG)	Velindre
Carl Davies Via VC	NWIS
James Walford (JW) Via VC	Swansea Bay
Cath Jones (CJ) Via VC	Hywel Dda
Heidi Dobbs (HD) Via VC	Cancer Networks of Wales

Apologies

Deb Usher (ABMU)
Adam Watkins (Public Health Wales)
Dawn Allan (WCISU)
Helen Roberts (Welsh Government)
Liam Allsup (WAST)
Lisa Powell (NHS Wales Health Collaborative)
Sian Richards (Swansea Bay)
Gareth Griffiths (NWIS)

1. **Welcomes and introductions**
   The chair welcomed the group to the meeting and the attendees introduced themselves.

2. **Minutes agreed**
   Due to time restraints, it was agreed any feedback regarding the previous IQI meeting minutes would be addressed outside of the meeting.

3. **Actions log**
   Due to time restraints, it was agreed the actions would be shared outside of the meeting.

4. **Update on projects**

   4.1. Pathway ID
   HT provided a bit of background explaining the goal is to define a common definition for Pathway ID to link all events along a pathway. Without looking at the how at this point, we need to focus on the definition first and then we can look at what that means in the operating systems. The pathway needs to link in all events and resources, whether a pathway has been resolved or if an event is relating to a previous event. GC queried if we anticipate the identifier will follow the patient across boundaries. HT answered yes, there should be a patient/organisation centric. RTT is more organisation centric, we need to collect data in a meaningful way and link all events. RC provided an example of a pathway, as there was some confusion on how we would record a patient's pathway. For example, if a patient had a heart attack, this may not be the event that starts their journey as they may already be under cardiac diagnostics. We need to be able to link all this information together. CD added from a software point of view there needs to be core principals agreed first of what we're trying to achieve before we can look at how we're going to do it. DH presented some of the feedback received from health boards on a Pathway ID consultation. A question was raised by Swansea Bay in the feedback provided, if a patient declines treatment what would happen for their pathway. CD suggested if a patient declines treatment, this doesn't mean the problem is fixed therefore it shouldn't end their pathway as it may need re-opening in the future. HT added patient journey definition isn't as clear as it could be and that giving an example will help explain and give clarity. Primary care currently isn't included in the proposed definitions, could this mean it is looked at in two stages. An initial focus on secondary care and consider further increase of scope to include primary care later on. CD didn't anticipate primary care, however added from a system perspective it doesn't matter where the journey starts. TD queried that a lot of appointments occur in England, would these be included in the scope, HT answered ideally yes, further work would be required to look at how we could use intelligence in the data to incorporate these. RC suggested it may be worth consulting with GP practices to see if they record if all events relating to the same problem. HT added that clinical and QOF data is more important to GPs than recording events and how the appointments work.

   ACTION – DH to follow up for further feedback on the Pathway ID consultation from those who have not yet responded

   ACTION – DH to create flow chart to show Patient Journey

   ACTION – DH to share single cancer pathway start points document for feedback on suitability for adoption.

4.2. Patient Flow

HT briefly explained the background to the work relating to Source of Admission and Discharge Destination and the implementation of time fields into APC dataset. Aneurin Bevan have carried out a test for the addition of time fields. DB raised the issue of inconsistencies with time fields due to default times being used or ward clerks retrospectively inputting and not giving the correct times. Aneurin Bevan's process is different to PAS as its retrospective. CD added that the problem may not always be default times as the system could also be automatically filling the current time even though its being input retrospectively. DH pointed out there are significant spikes at some LHBs at 7am when shifts start. The feedback provided was that they're happy to add fields to the end of the data set however they're having issues including unfinished episodes. RC added that warehouse describes the issue as most current load checks rely on an end date being present, so it's difficult to include unfinished episodes as major process changes would be required. RC suggested that as load routines currently run on end date, would we be able to revisit the inclusion of unfinished episodes separately once the server migration has been completed. DH added that health boards have advised they're happy to implement and include unfinished episodes however this would currently error the quality checks showing organisations as having poor levels of compliance on all submitted unfinished episodes. HT agreed to park unfinished episodes for now, however it'll need looking at again in the future, HT also noted the need to look at medically fit for discharge next.

ACTION – DH check that we are receiving the data as per the published DSCN

ACTION – DH baseline work already completed on Medically fit for discharge & estimated discharge date

ACTION – CD to send LHBs the calculation relating to times

4.3. NHS Number

RC gave a brief overview to the group on the subject of NHS Number, explaining that currently not all patients have an NHS Number which is an obstacle against establishing the use of the field as the primary unique identifier. We are currently trying to initiate conversations with England to allow the allocation of NHS Numbers in Wales, as currently only England can allocate numbers. A further document shared with the group was a patent safety alert published by Welsh Government in December 2018, the document provides guidance on the recording of unknown patients. PM added the safety notice was piloted in 7 organisations in England. The pilot picked up that when a patient is unknown, they would guess their age based on appearance and estimate the DOB accordingly. He added they have queried with England how that works and what do they do with Welsh patients. RC continued that England are having much of the same issues with NHS Number that Wales are, so we're hoping to work collaboratively alongside them on the issue moving forward. The issue we have with the safety notice advising to estimate information such as DOB, we don't want such data feeding into EMPI. GC suggested could we use a default date if the DOB is unknown. RC answered some systems won't accept a default date so changes would need making to do this. PM added that if the NHS Number is unknown in England, they use Z's.

ACTION – GG to arrange a subgroup for focus on NHS Number topic to look at options moving forward.

ACTION – GG to produce paper to share at council once it's clearer how we're going to work with England

4.4. Scope of National Data Set

DH explained we are planning to replicate what we've done for the Outpatients data set within the APC data set by including non-consultant nurse led activity. An impact assessment has already gone out, we're still receiving responses. HT added it doesn't include Junior Doctor activity though. HT advised this can continue to move forward through the standards assurance process.

ACTION – DH start a Development Proposal for WISB

4.5. Outpatients Status

DH explained this is to further increase the scope to incorporate therapies, definition for outpatient consultation. HT pointed out we need to consider an overlap with community. RC added that we're trying to get logic that you need to be able to collect activity and where the activity took place, regardless of where the data is recorded (WCCIS or PAS). Data standards has a meeting arranged with Welsh Government to confirm what is categorised as non face-to-face contact with patients. England already have a list so we could see if this validates what we want. RC added that we need to include all visual consultations not just what some organisations want to look at. Sian Musto from the Data Standards team is now involved in this piece of work too. GC mentioned this work is also coming through the Planned Care Agenda.

4.6. Core Reference Data

DH updated the group on the status of core reference data, a draft DSCN has been produced and was shared with the group and Gareth Griffiths had provided a summary on the changes since the last IQI meeting. RC added further that there is a huge drive for this in WCCIS to ensure its adhering to a standard. We are not ready for implementation in other systems yet as it will disrupt messages. Updates and granularity need adding to items e.g. sex and gender. A further workshop is to be held for sex and gender followed by further impact assessing. HT concluded that once this has taken place the plan is to take these to WISB.

5. Usability

DH presented to the group slides showing the recently produced Clinical Coding Dashboard, the purpose being to show this as an example of what a Data Quality Dashboard could look like. The dashboard recognises a user's NADEX and will then limit use and visibility of the data dependant on job role or organisation. For example, users would be able to view overall performance for all health boards, but to break down the errors to record level would only be able to view records for their organisation. A usability sub group has convened between meetings to discuss what could be included in a Data Quality dashboard. HT added that we already have VASS checks which could be replicated for the dashboard but also use the 6 points of data quality to see what other checks we could include in reporting. This would allow organisations to gage the usability of certain fields. DH concluded that if we can agree within the sub group on what we want, then he could approach the publishing team to see if this is possible. Queries have also been sent to Welsh Government contacts to query any suggestions for inclusion and to question which fields a key for analysis to help prioritise where the focus of the quality reporting should firstly be directed.

ACTION – DH to speak with the Publishing team on plans for a data quality dashboard and to follow up with Welsh Government

6. Default Codes

DH has spoken to the WPAS team and been informed they are in the process of creating a Data Dictionary for WPAS and could look at adding a flag for fields to identify if it has a default populated value. The WPAS team have also informed us it would be largely time consuming to remove all default codes from the system. RW explained that BCU have a list of default codes they want removing, they have already removed a code for referral source. HT added we need to share which items we'd like to look at removing and understand what would be involved in removing the default codes. RW fed back that it was relatively easy to turn off the default codes they've already removed, however it would involve a lot of work to remove them all. HT suggested a phased approach to removing the default values for fields in WPAS based on the importance of the fields.

ACTION – DH to create prioritised list to initiate removing default values gradually and contact WPAS team to ensure this is possible

7. Review Submissions

7.1. APC Waiting Times

SD explained she has carried out a review submission for APC – Waiting Times for Elective Admissions. The review has found that Health Boards aren't submitting comparable data, as every organisation is submitting differently. Some are submitting four blanks for Duration of Elective Wait where as others are submitting '9998' or '0000'. Another issue uncovered was that Cardiff & Vale are still using retired admission method code 14 with no clear reason as to why. SD went on to further explain that for the field Waiting List Date, the date entered should either be the same as the Decision to Admit Date or be a later date, the review has found that not all Health Boards are providing as such. GC added that they have several dates in different places, so they don't know which is the right one. For example, there is a date in PAS that adjusts depending on other factors. HT concluded that we need to get stakeholders together to establish clarity around waiting times. It may also be a good idea to take to Heads of Information.

ACTION – SD to arrange meeting with Health board contacts and WPAS team to discuss correct Waiting List Dates to be used

8. Messages for WCIC

None stated.

9. Any Other Business

None raised.