Information Quality Improvement (IQI) Working Group Minutes

Date: 04 June 2018 **Time: 13:00 – 16:00**

Venue: NWIS Cardiff Taf Meeting Room, 1st Floor, Tŷ Glan-yr-Afon, 21 Cowbridge Road East, Cardiff. CF11 9AD

Helen Thomas (HT) **Chair**	NWIS
Adam Watkins (AW)	Public Health Wales
Cath Jones (CJ)	Hywel Dda
Claire Langdridge (CL)	Hywel Dda
Daniel Hughes (DH)	NWIS
Dawn Allan (DA)	WCISU
Deb Usher (DU)	ABMU
Dilwyn Bull (DB)	Aneurin Bevan
Gareth Griffiths (GG)	NWIS
Graham Crooks (GC)	Cwm Taf UHB
Heidi Dobbs (HD)	Cancer networks of Wales
John Morris (JM)	WG
Julie Townsend (JT)	Velindre
Katie Evans (KE)	NWIS
Liam Allsup (LA)	WAST
Michelle Williams (MW)	Powys Teaching HB
Richard Westwood (RW)	BCUHB
Sian Richards (SR)	ABMU
Sue Brown (SB)	WAST
Trevor Davies (TD)	Powys Teaching HB

Apologies

Andrew Gunney -Powys Teaching HB
Helen Clayton - Public Health Wales
Lisa Powell - NHS Wales Health Collaborative
Rebecca Armstrong - WG
Rebecca Cook - NWIS
Richard Westwood - BCUHB
Ricky Thomas - NHS Wales Health Collaborative

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

2. **Minutes agreed**
   The Minutes for the previous meeting were agreed.

3. **Actions log**
   All actions were either complete or would be addressed under subsequent agenda items.

4. **Quality of Datasets**
   JM spoke of feedback so far received on the usability scoring system and suggested 2 ideas for formalising. Firstly JM detailed the work ABMU are carrying out around the kitemark, stating the benefits of the idea as a tool for assurance, given the limitations of current assurance processes. It was proposed that the kitemark would be used for existing datasets and, in doing so, it would be possible to achieve a greater level of granularity, along with better validity and completeness of data. Secondly JM suggested the usability score be utilised to compliment the kitemark, not necessarily as a scoring system, but perhaps as a tool to log issues and improvements for all to access.

   HT questioned how far ABMU had got in terms of implementing the kitemark and how realistic and widespread implementation was. DU explained that the health board were currently carrying out QA work on the RTT process. The kitemark had been implemented for RTT with performance being reported in a scorecard to the Board. Implementing should be simple and incorporated as a part of day to day work. The obstacles encountered were more around engagement rather than technical issues. SR noted that although there would be long term benefits, the resources required to implement this would be considerable. This could not be rolled out beyond RTT at this time without an investment to mandate.

   GC praised the idea, but also added that there would be ongoing issues due to the lack of resource to push this forward. There was a recognition that this would need to be mandated via a WHC to give it the necessary profile. HT stated that the concept was sound, but that there was a need to address the ability to adopt this. It was suggested that NWIS could support this but that this would need a smaller group formed from members of the Working Group to take forward. This group could identify the sorts of checks required to provide more comprehensive data quality assurance.

   ACTION – Investigate feasibility of kitemark via the data usability subgroup

   HT stressed that the ability to validate and sign off data was important in terms of accountability and ownership of data. The current VAS system provided this functionality as well as the ability to provide caveats and this would need to be retained as part of the development of a new Switching Service.

   DU stated that the national data validity and consistency reports were of limited use as they do not show the percentages when targets are being met. She also explained that a number of the indicators were dependent on system development which was out of the health board's control. MW also queried whether there was any tracking of data quality trends, based on the validity

and consistency reports. GG explained that there is a national data quality toolkit available via the RePortal which provided the percentages and underlying figures for each indicator as well as the ability to look at trends over time.

ACTION – DH to share link to RePortal with the group.

HT noted that the current Switching Service processes 90% of data with the remaining 10% being a SQL to SQL transfer. The direction of travel is to move towards more SQL to SQL processing, and this had already been implemented for the Maternity Indicators data set. JM queried what the current status of the maternity dataset data quality checks was. GG explained that NWIS were in the process of implementing these as only basic data integrity checks were being employed at present.

AW informed the group of conversations held with Observatory as they carry out a lot of analytical work, but do not currently have a member on IQI. HT queried if it would be useful to request a member join the group.

ACTION – AW to contact observatory and request a member attend IQI meetings.

5. Update on projects

5.1. Real time information

1.1.1 Delayed discharges

In the lead up to the meeting, there had been some discussions around how delayed discharges were being reported, particularly in the context of WCCIS. GG noted that whilst WPAS does include the functionality to record delayed transfers of care (DTOC), this was not the primary source of information for national DTOC reporting.

MW informed the group that DTOC issues were raised at a recent HOI meeting, and noted that as an information department tasked with providing bed data reports with DTOC data, it appeared that everyone is doing something different with DTOCs. HT noted that the current measure was brought in in 2000 as a temporary measure and was no longer fit for purpose. A strategy needs to advise how this information can be captured on the wards. A need exists to review definitions and standards to identify the nature of the delay and how it is recorded. It was also noted there could be an overlap on this work and the nursing documentation project. Currently only discharges data is available, with no standard view of live data i.e. to include patients currently in a bed. The group acknowledged that PAS does not support patient flow, and GC added that with no overall clarity, each health board could be using different methods locally.

HT suggested that the Welsh Clinical Portal (WCP) could potentially provide real time admission and discharge information. GC described the new whiteboard system and ‘app’ being piloted on wards as part of the National e-Patient Flow Management (NePFM) project, which operates using a simple drag and drop system to track patients and beds. This system linked to WPAS with mappings ensuring that the system was populated with the appropriate administrative information. GC explained that there were business rules built into the system to

map the information. SR was mindful of the need to understand exactly how the interactive whiteboard system would populate WPAS.

1.1.2 Time stamps in APC

KE informed the group that an impact assessment had been sent out regarding time stamps to internal system contacts in NWIS and externally for health board feedback. Internal responses had been received but no health board feedback as yet. It was suggested that the impact assessment should be recirculated to members of the Working Group.

ACTION – KE to recirculate time stamps impact assessment to the Working Group

DB explained that Aneurin Bevan could provide time in their submissions, but it may just be a defaulted value and not reliable.

1.1.3 Source of Admission / Discharge Destination

GG informed the group that it was agreed at the last WISB meeting that rather than submitting review submissions to WISB directly, they could be considered by IQI before being circulated to WISB for final approval. Consideration of review submissions would previously have been part of the remit of WISB, however IQI may be a more appropriate forum for these, whilst this would also ease some of the pressure on WISB given the volume of new standards developments going through the assurance process. If the recommendation was that there was a requirement to change an existing standard, then that would go through to the assurance process in the form of a development proposal anyway.

The group then fed back on the proposed codes in the review. HT queried the meaning of “part 3” in the definition for code *23 – local authority part 3 residential accommodation or foster care.* It was agreed that this required further clarification. AW suggested that part 3 may have been part of the National Assistance Act (1948).

ACTION – KE to contact social care colleagues to investigate the meaning of ‘part 3’ in relation to SOA/DD

GC suggested confusion may occur in using the word residential in multiple Source of Admission values. HT was unsure on code 29 and proposed rewording the ‘respite’ sentence. AW added that 29 could affect the capture of ‘no fixed abode’ or NFA due to overlapping criteria such as hostels. HT also added that more clarity was required to define cases of permanent and temporary residents such as with students at university.

DU questioned if values will need to be in line with WCCIS and what is meaningful for local authorities in terms of Social Care as well as Health. The group agreed that these would need to align.

ACTION - DU to check alignment with lists in WCCIS

GC noted that staff using the provided list of values will be making a snap decision and as a result we should look to limit the number of options available and avoid lengthy definitions.

DB queried value 87 and the use of the word 'private' in the definition. AW questioned whether this meant private patients or private hospital. The group agreed that the definition of this value needed to be clearer. GC suggested that the word 'includes' in definitions can be misleading as this can be misinterpreted as being something more specific than what was intended, e.g. 'including mental health' was not intended to be used exclusively for mental health but this is how it had been interpreted.

HT proposed changing the definition for 79, as 'not applicable' is not clearly defined.

ACTION – KE to make updates to review document and complete impact assessment.

5.2. Scope of national data sets

GG explained the background of this work to the group, noting that the Outpatients data set was missing nurse led and non-traditional activity. Nurse led and therapy activity had been proposed for inclusion in Phase 1 of the work. Definitions had been drawn up and an impact assessment issued to the service.

HT acknowledged the need for modernisation in this area and stated that getting definitions agreed for these other types of activity would be a big step forward. DB added that it would be preferable to have definitions agreed and completely signed off before rushing to process.
GG explained that Lisa Powell was keen to move this forward for the purposes of processing the annual costing returns.
HT suggested it would be helpful to get an implementation plan for phases 2 & 3. This should be added to the agenda for HOI to understand impact on 2017-18 WCR process.

5.3. Core Reference Data

GG informed the group that a DSCN was sent in December stating requirements for newly procured systems. The next step is to fully impact assess for existing national systems.

ACTION – GG take forward to the WRDS assurance group then distribute formal impact assessment.

5.4. Pathway Identifier

GG informed the group of conversations with Carl Davies (NWIS - Software Development) and was updated this was still waiting on funding. It was suggested this is followed up at future IQI meeting.

HT said the first test of this will be in the PAS implementations at ABMU, Boundary changes may inform solution.

5.5. NHS Number

DU updated the group that survey monkey results had been taken to demographic SMB. The results have shown NHS number is often not the primary ID. For example the analysis carried out at ABMU revealed 10% of records did not have an NHS number altogether. DU also informed the group that currently only primary care can generate a new NHS number for a patient, so the possibility to create one does exist.

HT Advised this be added to agenda for information sharing group session with UK standards board.

ACTION – GG to take work forward to Demographic user group

ACTION – GG to meet with ABMU & eMPI contacts to discuss way forward

6. Messages for WCIC

No group updates.

ACTION – to share the development update report