



Information Quality Improvement (IQI) Working Group Minutes

Date: 13 March 2018

Time: 13:00 – 16:00

Venue: Innovation area, 2nd Floor, Tŷ Glan-yr-Afon, 21 Cowbridge Road East, Cardiff. CF11 9AD

Helen Thomas (HT) Chair	NWIS
Gareth Griffiths (GG)	NWIS
Daniel Hughes (DH)	NWIS
Katie Evans (KE)	NWIS
Rebecca Cook (RC)	NWIS
Deb Usher (DU)	ABMU
Graham Crooks (GC)	Cwm Taf UHB
Claire Langdrige (CL)	Hywel Dda
Lisa Vipond (LP) Via VC	Public Health Wales
Michelle Williams (MW)	Powys Teaching HB
Sian Richards (SR)	ABMU
Adam Watkins (AW)	1,000 lives
James Walford (JW)	Delivery Unit
Cath Jones (CJ)	Hywel Dda
Julie Townsend (JT)	Velindre
Rebecca Armstrong (RA)	Welsh Government
Heidi Dobbs (HD) Via VC	NHS Wales Health Collaborative (Cardiac Network)
Bradley Kearney (BK)	Welsh Government (Digital Health & Care)

Apologies

Chris Newbrook ([CN](#)) - Welsh Government (Digital Health & Care)

Helen Clayton ([HC](#)) – Public Health Wales

Dilwyn Bull ([DB](#)) – Aneurin Bevan

Richard Westwood ([RW](#)) - BCUHB

Ricky Thomas ([RT](#)) – Cancer Network of Wales

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. Usability score

GG gave a brief refresher on the concept of the usability score, as presented by John Morris at the last IQI working group. He explained that, following a request to seek advice from Heads of Information at the January meeting, the score had been presented to the Heads of Information meeting in March. The feedback received on the day was summarised and reported back to the group. Although the group were supportive of the concept in principle, they expressed concerns as to its viability, including the identification of individuals with the necessary expertise and capacity to produce and maintain this resource.

AW suggested that when users encounter an issue, the issue could be raised, severity stated, together with details of the dataset and health board affected. This information could be communicated via a central knowledge base, stressing that the *reason* for assigning a score was in fact more useful than the score itself. This would mitigate the risks associated with assigning a score and allow recipients to form their own judgement of fitness for purpose based on their intended use.

HT noted the frustration with the current way of working, particularly as this meant that UK Statistics Authority accreditation could be threatened when official statistics are published and later retracted due to data quality. She questioned whether this proposed approach would address this and help prevent this situation occurring, suggesting that some sort of manual verification and sign-off of data submissions as 'fit for purpose' was necessary. RC suggested that, to some extent, communication already existed via the Switching Service upload and Validation at Source (VAS) sign-off.

RA agreed with AW that a location to log data quality issues would be useful to Welsh Government. RC noted that some issues may be static whereas others will peak and drop, e.g. a PAS upgrade can greatly affect the month of implementation then drop off again. She suggested that data quality information could be communicated to users of data via a newsletter.

HT explained the need to address publishing issues with statistics, and that known issues in the service are not necessarily shared prior to publication. She suggested that a task-and-finish group was set up to discuss and address the issues that John had raised.

ACTION – DU, GC, DH, AW & RA to meet to discuss the way forward for data quality visibility.

DU suggested that the kite mark premise developed by ABMU could be used as a monitoring tool, as it has already been used locally in conjunction with the RTT data to focus on specific issues one by one.

ACTION – DU to circulate kite mark work and background information with the group.

RC commented that a more formal process was necessary to establish when it is appropriate to publish information sourced from new datasets.

HT stated that all datasets should flow through an official assurance process, and noted the absence of a final check to confirm if data can be published and is of a suitable quality to share. RC told the group that use of the WISB Review Submission process should help in confirming if the standards put in place are effective, as well as to ensure that messages are fed back to all stakeholders.

5. Data quality governance

GG explained that the drafted data quality report and policy specifications had been shared at the Heads of Information meeting in March. The group were supportive of the adoption of a national approach to standardising the content of data quality policies and reports in principle. However, they questioned whether this would have the required driving force behind it without it being mandated at board level. MW explained that, following that meeting, she had shared a Ministerial Letter from 2008 that did just that.

RC suggested that there might be a need to reissue the instructions contained within the Ministerial Letter to formally reiterate the mandate and perhaps include measures as part of the national performance framework. HT suggested that, once agreed, the annual report specification could be issued to the service via a Welsh Health Circular (WHC).

ACTION – RC to approach CN regarding the potential for reissuing WHC to reiterate the Ministerial Letter which mandated the reporting of data quality at Board level.

ACTION – RC liaise with BK in relation to the potential scope for data quality measures to be included in the next annual performance framework.

The group went on to review the draft specification for a Data Quality report in detail.

HT noted that the role of the Senior Information Risk Owner (SIRO) is not currently mentioned in the roles and responsibilities section of the specification. SR confirmed that most English trusts and Welsh health boards have SIROs in place.

HT also stressed the need for some narrative to support the numerical information.

It was also advised that the clinical coding section of the report should be made more specific, including the level of completeness and timeliness, and if the data is fit for purpose. GG also advised that, some health boards, the coding targets were treated as annual targets effectively, when in fact these should be adhered to on a monthly basis throughout the year. GC added that the way the coding is handled is a historical situation, and that resourcing issues continue

to exist. However, HT explained that there was a need to learn from the approaches adopted by Cardiff and Vale and Aneurin Bevan health boards.

RC explained that there was a need to capture 'date coded' to accurately measure performance against the new 30-day target, but noted that this suggestion had been dismissed by the national Clinical Coding Steering Group (CCSG), as the 30-day coding target was considered impossible to achieve. HT pointed out that non-compliance did not constitute valid justification for not reporting this information. SR identified the benefit of having a target even if it will not be met, as this will then escalate the need for quality in the service. GC added that often the writing off of uncoded records is due to capacity issues. RC informed the groups of clinical coding work carried out by NWIS showing coding behaviours as a result of targets. It was agreed that this information may be useful to share with the group at the next meeting.

ACTION – DH to contact Kylie Bainton (NWIS) to request copy of the clinical coding improvement report and share with the group

SR stated that a previously encountered issue occurred due to local and national coding targets being in use at the same time. These targets would contradict one and other so the decision was made to commit to trying to achieve targets for national reporting. HT suggested that RC could take coding issues to future HOI meetings.

ACTION – RC to take issues on coding targets to HOI

SR suggested that the Achievements section on the specification be renamed 'Review of the year'. This will allow organisations to summarise the current situation, successes and raise or escalate issues.

HT noted that the targets section of the specification should not focus solely on national targets but could include the local focus too. However SR stated that as the focus will be on the national return and that it would be difficult to baseline quality outside of that with the resources currently available.

It was agreed by the group that reports should be produced in the autumn following year end sign off of the data. DU commented that as data quality is often down the list of priorities in a health board, producing these reports can be a good opportunity to share work with others and make people more aware of what data quality work is done.

The group then looked at the draft data quality policy specification. HT explained that this should be introduced in terms of "a good data quality policy should incorporate these principles."

SR questioned the scope of the policy, pointing out that this would be applied to national systems but not necessarily to other systems such as RADIS, LIMS or theatre systems. However, that didn't necessarily mean that it should not cover data captured elsewhere. DU mentioned that ABM produce a baseline of systems, which could add additional information such as "is training included?" to track the known number of users and measure what level of data quality training has been given.

HT advised that policies need to address different roles and responsibility levels, clearly defining responsibilities of a user, product specialist, etc.

ACTION – DH to make changes to data quality policy and report specifications as advised then share with the group.

RC added that, following on from the presentation of this work to Heads of Information, a report on progress of the group to date should be submitted to the group on a regular basis.

ACTION – GG & DH to produce a report to share with Heads of Information describing progress on IQI work streams.

6. Update on projects

6.1. Real time information

The group were presented with a list of draft definitions associated with data fields used in WPAS to capture information relating to patient flow. GG explained that the starting point for the analysis was to look at time and date related fields in PAS that do not currently have definitions in the Data Dictionary. These could provide information around patient flow at a national level.

RC informed the group of the confusion surrounding Hospital Stay Start Time, the first item on the list, particularly as to whether this is based on a decision to admit or on the admission time. HT suggested that the time starts on actual admission and not decision to admit.

Further obstacles to holding real time information were discussed, GC stating that in order for the details of a patient to be entered onto a system they need to be admitted but, at that stage, they may not necessarily have been assessed. RC also commented on major issues such as, in some health boards, patients can be admitted and still active on the ED system at the same time. It was agreed that, although these issues would need to be addressed at some point, these would not be resolved now.

The discussion moved on to consider the definition for Estimated Discharge Date. The consensus was that the term *Predicted* Discharge Date or PDD is preferable to Estimated Discharge Date. By capturing this information centrally, it was felt that the use of PDD could be monitored on a national basis and inform service improvement. However, HT pointed out that PDD did not necessarily drive workflow, so the impact of capturing this information should also be considered. SR was keen to point out that there needed to be a clearer distinction between PDD and Medically Fit for Discharge Date.

The group then considered the requirement for Arrival Time to be captured via the national APC submission. GC requested that seconds are removed from all time fields in the data, with the format restricted to capturing hours and minutes, i.e. HH:MM. HT advised that there was an argument for capturing the time element for all date fields within the APC data set. This was agreed as a way forward. RC deemed the next step would be to initiate an Impact Assessment to establish the required resources and what problems may be encountered with the changes to the national database.

ACTION – GG to issue Impact Assessment to the service to understand the implications of introducing the Time element to APC

A report on Source of Admission and Discharge Destination codes completed by KE was presented to the group. This included a proposed reduced list of values based on analysis of the data and health board feedback.

GC commented on the potential for confusion with usual place of residence as an individual's usual place of residence may be a care home, but this was listed separately. The group agreed that the current list of definitions lack clarity. HT explained the need to differentiate between 'own home' and 'residential/care home', and that there was probably

a requirement to capture 'hospice' separately too. GC suggested that NHS Digital had a clearer definition.

HT felt that the descriptions associated with these values could be more meaningful and readable to help those capturing the information in systems to make informed choices. AW suggested that No Fixed Abode or NFA should have its own separate value given that it is not relevant to any of the existing values. HT stressed that it would need to be established whether letters could still be sent for patients assigned NFA, e.g. to a nominated address.

HT also suggested that the reference to mental health in value *87 - Patient transfer from non-NHS hospital* should be removed. Although it states that mental health is *included*, the fact this is singled out might be interpreted by users as a mental health-only value and they may avoid using this value for general private patients.

The values agreed by the group for inclusion in the rationalised list were:

- own place of residence,
- nursing and care homes,
- NFA,
- penal establishment,
- internal transfer,
- external transfer, and
- Private hospitals.

ACTION – KE to adjust list of values following the group feedback and work with Data Standards to initiate an Impact assessment.

6.2. Scope of national data sets

GG informed the group that scope of the Outpatients data set was being taken through the Information Standards assurance process and that impact assessment results were being collated.

Members of the group felt that the planned changes could introduce inconsistency. DU noted that, if using WPAS, a different process would be required for non-face to face appointments and therefore, changes to systems could be required. GG commented that there was variation in adherence to the current scope that meant the data was already inconsistent as is, and that these changes were intended to improve consistency. He explained that the changes would be introduced in phases as part of an iterative approach, and that no changes were proposed for 2017-18 data. The new standards would apply to 2018-19 activity.

HT was supportive of this approach and suggested that NHS England may have a definition for nurse-led activity which could be used as a starting point.

6.3. Core Reference Data

GG informed the group that a DSCN had been issued, and that following the discussion at the previous working group meeting the item 'gender' had been removed pending review. HT suggested that this should be incorporated into implementation plans for national systems. RC stated that defining values is one issue, but implementing is a huge task. The process will need to be carefully managed.

6.4. Pathway Identifier

HT suggested that this should be picked up with RC and Carl Davies (NWIS - Software Development). SR noted that a meeting to discuss this had been scheduled in for February but had been cancelled. She expected this to be reconvened by April to identify work streams etc.

6.5. NHS Number

DU explained that a Demographics SMB meeting would take place week commencing 19th March, with a paper on NHS number being presented. This group would take this work forward. She outlined some potential implications for allocating NHS numbers to overseas patients in terms of eligibility for NHS care.

HT reiterated the intention to mandate the use of the NHS number as the primary patient identifier and the need to work with NHS Digital, as well as colleagues in Scotland and Northern Ireland.

ACTION – DU to identify points of contact for NHS number in other Home Countries with a view to setting up a meeting

7. Messages for WCIC / 8. WISB Review

HT advised that the ToR for IQI should be revised to reflect the changes to the WISB governance structure. Progress against IQI workstreams should be routinely reported to WISB. She also suggested that IQI should report to WCIC and Heads of Information on a regular basis.

ACTION – GG to update IQI ToR and share with the group

ACTION – GG to produce bimonthly report to be shared with WISB, WCIC and Heads of Information