NHS Intensive Support Team Information Sheet

GOOD PRACTISE APPROACH TO RTT DATA QUALITY

Introduction

The aim of this summary is to list a number of data quality policies and procedures which when embedded within a healthcare provider, are in the view of the IST representative of good practice. This has been written by the Elective Care Intensive Support Team (IST) and while not data quality experts this paper has been compiled based on the knowledge and experience acquired through working with a wide range of acute and community provider organisations.

1) Data quality strategy/policy

The organisation should have in place a clear, concise data quality policy or strategy written in such a way that all staff groups understand its contents and the part they play in implementing the policy. Such a policy will set out what the organisation does each day, week, month and quarter to improve data quality and who undertakes each task. The policy should strive to answer the question "How can the Board be assured about the data being reported – both internally and externally".

2) Data quality dashboard

A data quality dashboard ought to be in place which lists no more than 5 key indicators. The indicators chosen 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 sub specialty level if appropriate.

Common examples are;

- Missing / incomplete clinic outcome codes by specialty/ clinician.
- Incompatible codes e.g. clinic outcome code of discharge to GP and PAS code of add to waiting list or active monitoring or further OP appointment. Clinic outcome code of active monitoring and PAS code of patient DNA
- Patients on the admitted waiting list with TCI dates in the past
- New referrals unattached to a waiting list (OP ordinarily).

3) 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 0-1 week waits, 1-2 weeks 2-3 weeks etc. and not focus on clock stops or incomplete pathways that are over 18 weeks.

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 mechanism to feedback results to correct any systemic failures and conversely recognise where improvements have been made. Areas of concerns should feature on the data quality dashboard and where appropriate be escalated to the organisation's risk register to ensure visibility.

4) Clear lines of responsibility

If audit results illustrate inaccurate or incomplete recording in a particular specialty, it should be clear either via the data quality policy or via a standard operating procedure, whose responsibility it is to act upon this information. This may be through a central team or operational managers within 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.

5) Validation

Validation of RTT data is common to all providers. Most organisations fund staff whose sole purpose is to validate RTT data. Turnover in these staff groups is often high and is increased when the posts are funded on a temporary basis. Substantive funding minimises the risk of high turnover and recognises that improving data quality is a continuous process.

6) Frequency of validation

The work to validate RTT data should not be a monthly task. Instead validation, correction and improvements to the quality of the data need to be made weekly and ideally on a daily basis. Because performance is judged on the monthly data it is inevitable that the monthly submissions receive greater attention. To assess what additional 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 would indicate the organisation is overly reliant on month end processes which are under greater time pressures and present a risk to the reported performance. By spreading the validation effort across the entire month, this risk is minimised.

7) Training

Comprehensive training should be available to any staff (temporary and substantive) that has responsibility for recording or documenting patient pathways. The knowledge and insight gained through regular validation must be incorporated into this training of key staff.

This needs to be at a level of detail relevant to the job roles of staff but should include as a minimum

- Ad hoc training of teams and/or individuals where repeated errors, corrected through validation, are identified.
- Training at staff induction to a level relevant to their role
- Regular refresher training (if possible linked to mandatory training refreshes)

Without a) (above) the long term benefits of regular validation will not be realised and errors will continue to be repeated and corrected indefinitely.