Quality Assurance Policy

Review Date 12th December 2019
Next Review Due 12th December 2021

Physiotherapy2fit Ltd is committed to ensuring that, as far as it is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the basis of their age, disability, gender, race, religion/belief or sexual orientation. Should a member of staff or any other person require access to this policy in another language or format (such as Braille or large print) we will do our best to provide this in a format the user is able to access. Physiotherapy2fit Ltd will do its utmost to support and develop equitable access to all policies. The Director is responsible for ensuring staff are aware of Physiotherapy2fit Ltd policies and that staff adhere to them. It is also the Director's responsibility to keep staff up to date with new policy changes.

Staff are responsible for ensuring they are familiar with policies, know where to locate the documents on Physiotherapy2fit's main website, and seek out every opportunity to keep up to date with them

Independent contractors are expected to identify a lead person to be responsible for ensuring staff employed within their place of work are aware of Physiotherapy2fit Ltd policies.

Policy Statement

Information is a vital asset, both in terms of the clinical management of individual patients and the effective management of services and resources. It plays a key part in clinical governance, service planning and performance management. It is therefore of paramount importance to ensure that information is efficiently managed, and that the quality of information can be assured and that it is 'fit for purpose'. This document sets out the P2F's policy in relation to Information Quality Assurance (IQA).

Summary

This policy is written to closely reflect the requirements of the Information Quality Assurance element within the Information Governance Toolkit. The Policy relates to all systems within the P2F.

Roles and Responsibilities

The Director is responsible for Overseeing progress against requirements.

She is responsible for ensuring the quality of the data collected and managed by the staff they control, monitoring and ensuring compliance with all P2F policies and procedures, and ensuring that staff receive appropriate training. These responsibilities must be reflected in their job descriptions.

The Director is responsible for coordinating the annual Information Governance Toolkit assessment.

Standards

P2F will establish and maintain policies and procedures for information quality assurance.

P2F will undertake or commission annual assessments and audits of its information quality in line with the requirements of the Information Governance Toolkit.

Wherever possible, information quality should be assured at the point of collection.

Data standards will be set through clear and consistent definition of data items, in accordance with National standards.

P2F will promote information quality through policies, procedures/user manuals and training.

Information, which is of high quality, consistent, timely, comprehensive and held securely and confidentially, is essential to support patient care, management and planning, enabling accountability in areas such as performance management and Clinical Governance.

The increasing demand for the provision of information means it is important that information is recorded promptly and correctly at source and is fit for purpose.

Operational Procedures

Documented procedures will be developed and maintained that cover the capture and recording of patient information for each relevant system.

Where appropriate, procedures should describe the processes for maintaining consistency between different systems that hold common sets of data and/or reconciling differences.

Validation Processes

Where errors or omissions are identified through validation or by internal users, corrections shall be made at the earliest opportunity to ensure integrity of data. Users should be made aware of the relevant timescales against which corrections should be undertaken.

P2F will ensure documented procedures exist to review and validate all waiting lists to ensure they do not contain patients who are no longer awaiting appointment.

Validation processes should also include verifying all relevant information including NHS number, date of Birth, address, overseas visitor status, ethnic origin and General Practitioner with the source (e.g. when a patient presents to Outpatient Reception, or telephones for an appointment in response to Choose and Book). Corrections should be made at the earliest opportunity.

Written procedures should be available for each key system that document how trends in information over time are analysed, and the processes for investigating and explaining any large variations.

In relation to Clinical Coding, P2F will develop processes to involve clinicians in the validation of information derived from the recording of clinical activity and to review Clinically Coded data through audit processess.

Service and System Changes

Procedures will be documented to ensure that changes to services (e.g. new staff, clinic codes etc) do not adversely affect information quality, by ensuring relevant P2F staff are made aware of such changes. New processes are in place to ensure that new clinics follow a robust sign off to ensure income and activity are correct.

Procedures will also be documented to ensure that system changes (e.g. software upgrades) do not impact on information quality.

Audit Trails

In line with general information security requirements, audit trails should be available for each key system, which link data items to individual input staff.

Data Standards

Where appropriate, NHS standard definitions, values and validation programmes should be incorporated within key systems. This is reflected in TM2 records obtained being altered to capture Key Performance Indicators.

Where appropriate, the Director will update local documentation to reflect changes to National standards, and ensure staff are made aware of these through refresher training or other appropriate communication methods.

Use of NHS Number

If a patient is referred via a body in the NHS then the NHS number will be used for all records and communication.

Audit of Compliance

P2F will monitor compliance against data collection procedures to ensure they are followed, and highlight areas where improvements need to be made.

Sample/spot checks will increasingly be introduced as an additional method for monitoring compliance.

In line with the requirements of the Information Governance Toolkit (IG Toolkit), P2F will undertake a regular audit cycle for accuracy checks on its patient data. This will incorporate checks against Outpatient and Waiting List data, reflecting the data items specified within the IG Toolkit. This requires comparison of data values held NHS Excel data Spreadsheet and those held on the electronic patient record (EPR). The results of these audits will be reported through appropriate channels.

Additionally, P2F will also undertake (on annual basis) the Completeness and Validity check for data, which is documented within the IG Toolkit. This requires an aggregated analysis of samples of data for each of the three data sets.

Training and Awareness

Training and awareness requirements should be determined for each key system by the Director. Training and awareness programmes should be included for both the operation of the system, and the collection of associated data, and staff should be clear over their responsibilities and the implications of inaccurate information.

Written training manuals should include information about associated data items, and there should be an opportunity for users to feedback on training and awareness sessions, in order that effectiveness can be monitored and improvements made where necessary.

Monitoring and Improving Information Quality Assurance

P2F will utilise a variety of external data quality reporting sources (e.g. CSP Quality Assurance standards) to assist in improving its information quality, through scrutinising such reports and taking corrective action where necessary.

An assessment of progress against the requirements for Information Quality Assurance, contained within the Health and Social care information centre (hscic) Information Governance Toolkit, will be undertaken on an annual basis, in line with current guidance. Annual reports and Action Plans will be presented to the Information Governance steering Group to demonstrate compliance.

Monitoring and Review

This Policy will be reviewed in line with changes to the Information Governance Toolkit requirements, or in the advent of other events that give cause for a review.