Somerset Partnership NHS
NHS Foundation Trust

DATA QUALITY POLICY

2016 – 2019

IM&T DEPARTMENT

This document should be read in conjunction with the
Data Quality Strategy
Record Keeping and Records Management Policy

Version:	1
Ratified by:	Senior Managers Operational Group
Date ratified:	March 2016
Title of originator/author:	Information Delivery Manager
Title of responsible committee/group:	ICT
Date issued:	**March 2016**
Review date:	**February 2019**
Relevant Staff Groups:	All Staff Groups

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference PA/Sep15/RMS	**Version** 1	**Status** FINAL	**Author** Information Delivery Manager
Amendments	Previously version v3,incorporated within the Information Security Policy,v4, v5,v6, now developed into this new policy.		
Document objectives: To provide a clear system of accountability and responsibility for data quality			
Intended recipients: All Trust staff			
Committee/Group Consulted: Information Communication and Technology Group			
Monitoring arrangements and indicators: Audit Committee, Integrated Governance Committee, Caldicott and Information Governance Group Key Performance Indicators are included in the data quality strategy.			
Training/resource implications: please refer to Section 6 of this policy			
Approving body and date	Caldicott & Information Governance Group	Date: February 2016	
Formal Impact Assessment	Part One	Date: November 2016	
Ratification Body and date	Senior Manager Operational Group	Date: March 2016	
Date of issue	**March 2016**		
Date of Review	**February 2019**		
Contact for review	Information Delivery Manager		
Lead Director	Director of Finance and Business Development.		

CONTRIBUTION LIST Key individuals involved in developing the document

Name	Designation or Group
All Group Members	Caldicott and Information Governance Group
All Group Members	Clinical Governance Group
All Group Members	Operational Management Group
Phil Brice	Director of Strategy and Corporate Affairs
Sue Balcombe	Director of Nursing and Patient Safety
Andrew Sinclair	Head of Corporate Business
Sara Harding	Head of Operations/Deputy Chief Operating Officer
Jean Glanville	Claims and Litigation Manager
Michèle Crumb	Head of Risk

CONTENTS

1. INTRODUCTION

1.1 High quality information permeates through all aspects of the delivery of patient care and is the responsibility of everyone involved in the delivery and support of that care.

1.2 Without this information we are unable to review or manage effectively, or provide others with assurance of the quality of our services.

1.3 Data quality is crucial and the availability of complete, accurate and timely data is fundamental to supporting patient care, management and service agreements for healthcare planning and accountability.

1.4 Standards exist both nationally and internationally regarding the responsibilities that all staff have in regards to maintaining good data quality.

- The Data Protection Act 1998 (from European Data Protection Directive) requires, amongst other things, that information held on computer systems is accurate and up to date.
- The IGT (IGT) requires organisations to ensure that good data quality exists along with the auditing of systems. (IGT itself is based upon international standards of ISO 270001).
- Records Management Act
- Francis Report 2013 made several recommendations regarding the use and quality of information.

1.5 The Trust's commitment to data quality is addressed at the commencement of an individual's employment. The IM&T Department provides access to systems as defined by the individual's new line manager. No access is given to any Clinical Records Systems until completion of the e-learning, class based or individual training.

1.6 All Clinical Systems in use by the Trust must comply with the principles set out in this document.

2 PURPOSE & SCOPE

2.1 Any system used for the provision of patient care is covered by this document, including medical or paper records where information is collected and used for the provision of performance, management or commissioning information.

2.2 This policy is intended to cover any system used for the provision of patient care, including medical or paper records where information is collected and used for the provision of performance, management or commissioning information.

2.3 The policy outlines good practice and identifies the roles and responsibilities of both the Trust and its staff in terms of data quality.

2.4 **National Requirement** - With the closure of the National Programme for IT (NPfIT), a greater opportunity exists to store and access many types of information, through propriety and open source applications, but new risks exist. With common systems being decommissioned and Trusts looking to procure replacement solutions with disparate systems and a national drive for integration (of Health and Social Care system), data quality and standards are vital to achieve this.

2.5 With this policy the Trust seeks to maintain context of its data within the NHS Data Dictionary definitions and for its data to be of the highest possible standard available within the financial and operational constraints that exist.

2.6 Patient data which the Trust sends to national databases including Mental Health Service Data Set (MHSDS) and the Hospital Episode Statistics (HES) via the Secondary Use Service (SUS), so information has a wider audience than just within the originating organisation.

2.7 Other national drivers exist including the imminent implementation of Payment by Results for Mental Health, and greater regulatory scrutiny.

2.8 **Local Requirement** - Consistency and compliance with National Requirement are essential as Trusts are measured and judged on both information and the quality of data compared locally and nationally for bench marking purposes.

2.9 Local Dashboards, commissioner dashboards, and regulators performance standards are some of the many ways data is being used and more detail is being demanded in this information, to provide an understanding of the services and the quality of care we provide to the local population.

2.10 Following the integration in August 2011 with Somerset Community Health the Trust has continued to review and, where appropriate, integrate services on to the Trust's Electronic Paper Record (RiO). This has led to a reduction in systems and a greater number of staff using a single system for patient record keeping, ensuring that consistency and accuracy increases.

2.11 Other clinical systems in use are being reduced, reviewed and improved to ensure where data quality gaps exist, these are tackled and the overall quality of information recorded allows for a direct improvement in health care delivery.

2.12 Electronic Staff Record (ESR) information also continues to improve with integrated data quality principles through all aspects of the data life cycle to ensure consistent and good quality data is maintained.

2.13 Where paper records exist these are monitored for compliance and reviewed in line with both data quality requirements and Department of Health Record Management principles.

3 DUTIES AND RESPONSIBILITIES

3.1 **Chief Executive** - Ultimate responsibility for data quality lies with the Chief Executive.

3.2 **Director of Strategy and Corporate Affairs** – Responsible for ensuring compliance against Information Governance Toolkit and all systems (paper or record) comply with the Data Protection Act.

3.3 **SIRO – (Senior Information Risk Officer)** – Held by the Director of Finance and Business Development, and chairs the quarterly Data Quality (Operational) Group which monitors the quality of information recorded by Clinical staff and ensures compliance of data quality to the standards set out by the Trust and IGT.

3.4 **Caldicott Guardian** – Responsible for ensuring that patient information is used and shared appropriately.

3.5 **Chief Operating Officer & Medical Director** - Responsible for ensuring that all staff involved in the delivery of care, record information in a timely and accurate way, that staff use the systems provided by the Trust, and that qualified staff comply with their professional codes of conduct (including record keeping)

3.6 **Director of Workforce and Organisational Development** – Responsible for ensuring that systems that record personnel information, including HR and training records are monitored and reviewed to comply with the IGT.

3.7 **Head of IM&T** – Responsible that all systems used for the purpose of Clinical Care and Record keeping is fit for purpose. Where issues or problems highlighted that influence the development of applications is performed to ensure compliance with IGT.

3.8 **IM&T Department** - Support the development of systems and the provision of interim solutions to combat highlighted data quality issues.

3.9 **Data Quality Lead (DQL)** – Held by the Information Delivery Manager who works with staff within the IM&T Department and maintains the Trust's Data Quality Log, which identifies, quantifies, prioritises and resolve data quality issues. This role is supported by Local Data Quality Leads (LDQL) who are designated by the Information Asset Owner.

3.10 **Information Asset Owner (IAO)** – Individual with responsibility for managing local Clinical systems used by the Trust for record keeping. They must ensure that all systems which they are responsible for comply with the NHS Data Dictionary (where appropriate) and IGT. They are supported by the Trusts Data Quality Lead, Information Governance Manager and Information Development Architect.

3.11 **Local Data Quality Leads (LDQL)** – Staff identified by the Information Assets Owner of a system to lead on data quality issues which exists within departmental systems used for clinical care delivery.

3.12 **All Staff** - Are responsible for recording all information in a timely, accurate and as complete as possible on systems provided by the Trust, to the standards set out by the Trusts Clinical Record Keeping Policy and their own Professional Codes of conduct (where appropriate).

4 EXPLANATION OF TERMS USED

Terms	Definition
Data Life Cycle	The period of time from entry onto a system to its use.
Health and Social Care Information Centre (HSCIC)	Organisation responsible for setting out NHS standards for the national data sets, fields contain within and the production of IGT.
Information Asset (IA)	Are identifiable and definable assets owned or contracted by an organisation which are "valuable" to the business of that organisation. An asset can be Software, Information, Physical (Infrastructure), Services, People or Tangibles (public confidence in an organisation, etc.).
Information Asset Owner (IAO)	Person who provides assurance on Information Assets for which they have day-to-day responsibility.
Information Asset Owner Administrator (IAOA)	Delegated authority for an individual, group of individuals or team of staff who carry out functions on behalf of the IAO in regard to data quality and system management.
Information Asset Register (IAR)	A list of the entire organisation's Information Assets.
Information Governance Toolkit	National guidance which sets out the standards which organisation must meet when handling data, incorporates the Data Protection Act and ISO 27001.
Data	A single field, or group of fields, which have little or no meaning when viewed in isolation at a clinical level. These items, however, are reviewed and monitored at an information management level to ensure good quality and accuracy.
Information	Detail about a Client's care, staff personnel record, clinical information or data sets required for national returns which are produced by grouping data together.

5 POLICY FRAMEWORK

5.1 Any system purchased by the Trust must comply with the Trust's procurement policy and as such no system must be upgraded or purchased without the knowledge of the IM&T Department and must comply with the Trust's IM&T Security Policy.

5.2 Prior to purchase/upgrade a system must be assed for its capability to meet the requirements of the Trust and IGT.

5.3 Once a systems is purchased it must be added to the Trust's Information Asset Register.

5.4 Following systems are currently in use by the Trust.

Application Name	System Status	Information Team Access	Subject to Data Quality Policy
DCRS Health Trainers Database	NHS Confidential	No	No
Digital Dictation	NHS Confidential	No	No
Document Upload System	NHS Confidential	No	No
Einstein Replacement	NHS Confidential	No	No
E-Roster	NHS Confidential	No	No
ESR (Electronic Staff Record)	NHS Confidential	No	No
ICNet	NHS Confidential	No	No
Learning and Development Training System	NHS Confidential	No	No
Paper Trail	NHS Confidential	No	No
Phone Book	NHS Confidential	No	No
Recruitment Process System (RPS)	NHS Confidential	No	No
Reporting Portal	NHS Confidential	No	No
Ricoh Auto Store Validation	NHS Confidential	No	No
Weekly Waiters Database	NHS Confidential	No	No
Blithe Lillie	NHS Confidential	Yes	Yes
Data Warehouse	NHS Confidential	Yes	Yes
Dental Helpline	NHS Confidential	Yes	No
IAPTus	NHS Confidential	Yes	Yes
Optimise(DRS)	NHS Confidential	Yes	Yes
Primary Link	NHS Confidential	Yes	No
R4 Kodak Carestream System	NHS Confidential	Yes	Yes

Application Name	System Status	Information Team Access	Subject to Data Quality Policy
RiO	NHS Confidential	Yes	Yes
Community Hospital Waiting List (CHWL)	NHS Confidential	Yes	No
Badger	NHS Protected	No	No
Cleaning Audit System	NHS Protected	No	No
COSHH	NHS Protected	No	No
e-Messaging to Somerset PC	NHS Protected	No	No
Generic Email Messaging (GEM)	NHS Protected	No	No
Jayex	NHS Protected	No	No
KACE	NHS Protected	No	No
Petal	NHS Protected	No	No
QOM	NHS Protected	No	No
RiO Audit Tool	NHS Protected	No	No
Task Scheduler	NHS Protected	No	No
Text Messaging System (TMBR)	NHS Protected	No	No
WorkPal	NHS Protected	No	No

5.5 **DATA ENTRY**

5.6 **All Staff** - will ensure that all information recorded in electronic or paper systems will conform to the following standards, where electronic systems are being used, the system will support and enhance the quality of information entered.

- ✓ **Validity** - All data entered by staff into Trust computer systems must be valid. *(Where codes are used to ensure compliance with national standards this will be seamless to the staff entering the data and be managed by the application, applying validation rules, notifying the user at point of entry where rules are being breached and request rectification).*
- ✓ **Completeness** - Staff will not enter default codes from pull-downs as a substitute for real data unless clinically appropriate to do so. *(All mandatory data items within a data set will be completed, wherever possible, through the use of the appropriate standard definitions with no local interpretation. The burden for this will be on the computer system to resolve and not on the clinician to perform).*
- ✓ **Consistency** - Data items should be internally consistent and within the context to which they have been defined. *(No local interpretation should be applied to nationally defined definitions).*
- ✓ **Coverage** - Data will reflect all the work done by the Trust and be recorded appropriately either electronically or on paper.

- ✓ **Accuracy** - Data recorded must accurately reflect what actually happened*. (Wherever possible, electronic systems will support the entry of information to improve the accuracy of information entered by the clinician).*
- ✓ **Timeliness** - The recording of all information should conform to thel Record Keeping and Record Management Policy and Professional codes of conduct. With the increase of electronic messaging to external organisations, recording of timely information is beneficial to other care providers and reduces the costs associated with keeping other health professionals abreast of changes in care. *(Electronic systems will further support timeliness by monitoring key timescales and providing reports to highlight areas where breaches are likely to occur).*

5.7 Every opportunity should be taken to check demographic details, including equality information relating to ethnicity, age, gender and first language for both patients and staff. Inaccurate demographics may result in important communications being mislaid or incorrect identification.

5.8 **IAO** - Where electronic systems are being used, IAO must ensure that wherever possible all reference tables, such as GPs and postcodes, will be updated regularly using information provided by HSCIC or approved reference sources. This should be within a month of publication unless there are serious doubts about the quality of the data supplied.

5.9 The Individual Asset Owner of each system, or area of responsibility, will have their own set of standards to which users of the system must comply. Systems in use by the Trust can be found on the Information Asset Register (IAR), which is maintained by the Information Governance Manager.

5.10 **Identification and correction of errors**

5.11 Careful monitoring and error correction supports good quality data, but it is more effective and efficient for data to be entered correctly the first time.

5.12 The Trust will use external data sources to review its own information, highlighting areas of poor data quality for action within the Trust.

5.13 The Trust will aim to be significantly above average in all indicators and will strive for 100% accuracy (where possible). The Trust will act on all enquiries and complaints from all users or providers regarding issues of data quality and validity

5.14 **The role of the Data Quality Group** – The Trust will have three forums to review and action Data Quality Issues:

- **Data Quality (Operational) Group –** The purpose of this group is to work with operational heads of service so that they understand data quality issues caused through the use of the clinical systems, this group is part of the Trusts Information Management and Technology Operational Group (IMTOG) and chaired by the Director of Finance and Business Development .

- **Data Quality (Information Asset Owners Group) Group** – The purpose of this group is IAO and LDQL to meet and discuss the compliance of their systems to IGT requirements and to highlight areas of poor data quality in their systems and to support the development of Local Data Quality action plans and where required inclusion in the Trust Data Quality action plan. The group is referred to as the Information Asset Owner Group and chaired by the Information Governance Manager.

- **Data Quality Forum** – This will be a small group of staff from within the IM&T Department who will meet on a routine basis to review and action specific items of concern contained on the Trusts Data Quality Log. Staff will be co-opted to fix problems as required by the Data Quality Lead for the Trust who has overall responsible for ensuring issues are reviewed and actioned on the log.

5.15 All three groups will report their progress into the Data Quality Log, with quarterly updates going to the Caldicott and Information Governance group via the Data Quality Report.

5.16 **Senior Management Operational Group**. Information about the service is provided via the Trust's Dashboard system to ensure monitoring and to improve clinical care. This group consists of Heads of Division and Operational Executive who will raise, where required, queries over data quality when they believe the information to be inaccurate with the Performance Manager for review and action.

5.17 **All Managers** - All managers must establish robust procedures for staff to be trained and supported in their work.

5.18 Monitoring the use of electronic systems must form part of the Clinical supervision process with frequency of system use and quality of record keeping being reviewed routinely.

5.19 **All Staff** - Where information is viewed during the normal operational use of the records; errors, omissions, or issues should be highlighted directly with either the LDQL or the IT Service Desk, who will the action appropriately the highlighted issue.

5.20 If any individual believes that information has been entered into an electronic system incorrectly then they should contact the IT Service Desk, where incorrect information has been recorded on paper based system then this should be reported to the Information Governance or Records Manager.

5.21 Reports will be provided to staff either through the clinical system or via an external reporting solution to allow for information to be displayed in an easy to read fashion.

5.22 **Clinical Focus** - Reports produced directly from electronic systems will be provided directly to clinical staff where they will be subjected to clinical scrutiny. These reports will be used to support teams with both clinical review and performance of teams, with issues or queries being raised allowing for the validity of data to be undertaken.

5.23 **Clinical Audit** - Reports produced and used to support the Quality Improvement Plans process, will be used directly from clinical systems to support this, and will be validated as part of the audit process to support clinicians in good data quality management and clinical care.

5.24 **Data Quality Lead & LDQL** – The Trust seeks to use the ITIL (IT Infrastructure Library – Best practice for IT Services to follow), method of Continuous Service Improvement, whereby it seeks to always improve on what has been produced through feedback from all recipients of its data.

5.25 Errors should be identified as close to the point of entry as possible. Methods by which this can be achieved are:

- ✓ Use of routine reports to highlight areas of poor data quality to staff. Where appropriate this will be rectified either by the relevant Information Asset Owner or LDQL.
- ✓ Programme of weekly and monthly error reports produced by the relevant Information Asset Owner or LDQL and actioned where appropriate.
- ✓ The production of information reports for both internal and external consumption, with queries or anomalies being reviewed and investigated and acted upon where appropriate.
- ✓ The use of external data sources to further support and identify data quality issues.
- ✓ The benchmarking of the Trust against nationally published data to ascertain its position and where appropriate seek clarification and system changes in order to improve areas of poor data quality of information.
- ✓ The use of internal and external audit reports to scrutinise data contained within systems and produced for performance, monitoring or commissioning purposes and for recommendations to be used to improve the quality of information.
- ✓ Establishing documentation to set out how to rectify the most common data quality issues or problems.

5.26 Any changes which require alteration following the identification of a data quality issue will be documented (including the minutes of the meetings where the issues have been actioned). This will include the process to be used by the relevant IAO or LDQL to rectify any data quality issues.

5.27 Where agreement exists for ongoing data quality issues to be addressed, (by a routine process) this is documented and performed until a permanent

solution has been found to the problem within the relevant application and will be reviewed on a Quarterly basis. The issue will remain on the Data Quality Log (DQR) even if a work around is available until a permanent solution is found. The item will be marked on the DQL "Workaround".

5.28 **The Information Team** – Already take responsibility for the monitoring of data quality within several of the Trust Electronic systems. The Trust is striving to move the responsibility of Data Quality away from LDQL into the main team, who have specific training and skills to spot these types of issues.

5.29 Over the past 2 years five systems have been migrated to the Trust's RiO system, issues regarding these systems are discussed on a weekly basis at the Information Team meeting. They seek to reduce the burden of Data Quality monitoring away from Clinical teams to allow them to focus on the delivery of clinical care.

5.30 Any new reporting requirements are the responsibility of the Information Team to ensure that the data can be collected and produced within the timescales required.

5.31 The Data Quality Log will be maintained by the team and provide quarterly reports to the Caldicott and Information Governance Group for review, with contributions from all LDL on the status of their systems. Coverage should include for this report compliance to the following standards and thresholds:

- Guidance produce by HSCIC and DoH.
- Regulator, (Monitor, CQC, etc.).
- Local Commissioners targets.

5.32 The report will detail current "hot" issues around Data Quality, and include specific information on developments which could have a significant impact on Data Quality or indicate Trust performance in this area.

- ✓ Newly published HSCIC changes in NHS Data Definitions via Information Standard Bulletins and how they affect current systems
- ✓ External view of Trust's Data Quality from various data sources including SUS Data Quality Dash Board, and other nationally mandated datasets
- ✓ Regulator published information and current CCG Contract compliance
- ✓ Compliance of Trust's Systems against IGT standards

5.33 **Performance Management Team** – Take responsibility for taking data produced by the Information Team and publishing this for either internal or external consumption.

5.34 Where issues or changes in trends are highlighted by the Team they should be discussed immediately with the DQL for the Trust to establish whether a problem exists.

5.35 Where issues of poor performance exist the team will work with clinical staff to understand the issues, and where appropriate ensure that information is

entered into the correct areas of systems to enable reports to function correctly and fed back to the Trust DQL.

5.36 Where issues are caused through poor use of the systems or where a lack of training exists, this will need to be fed back to the Trust DQL to be discussed at the Data Quality (Operational) Group for Heads of Division to action.

6.0 TRAINING REQUIREMENTS

6.1 The Trust will ensure that all necessary staff are appropriately trained in line with the organisation's training needs analysis.

6.2 Additionally, staff who have specific responsibilities under the Information Governance Toolkit, will, as required, have training applicable to their needs, once a skills gap analysis has taken place.

6.3 Senior Managers will require training provided by the IG Toolkit or the NHS Health e-learning packages

6.4 All staff within the Trust will have basic Information Governance awareness as part of their induction training.

6.5 Information Asset Owners are trained via the Trust's specific training covering this activity.

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 The Trust will use the Department of Health's (NHS IC) Information Governance self-assessment toolkit to monitor ongoing compliance. The underlying principles are set out in the standards called the HORUS model. This sets out that information should be: -

- **H**eld securely and confidentially
- **O**btained fairly and efficiently
- **R**ecorded accurately and reliably
- **U**sed effectively and ethically
- **S**hared appropriately and lawfully

8.2 **Monitoring arrangements for compliance and effectiveness**

The Trust will utilise the Information Governance Toolkit and related national initiatives, e.g. CQC for ongoing monitoring against information governance data quality standards.

8.3 **Responsibilities for conducting the monitoring**

The Caldicott and Information Governance Group will monitor overall compliance against data quality standards. Assessment reports of compliance will be produced by the Information Delivery Manager and presented to the Caldicott and Information Governance Group Quarterly along with, where required, compliance work plan.

8.4 **Methodology to be used for monitoring**

- Information Governance Toolkit
- Incident reporting
- Audits including internal and external auditors

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18: Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

Relevant National Requirements

Department of Health – Information Governance Toolkit

Data Protection Act 1998

Freedom of Information Act 2000

Access to Health Records Act 1990

NHS Records Management: Code of Practice 2005

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

11.1 References

Information Governance Toolkit version 13

11.2 Cross Reference to other procedural documents

Data Quality Strategy

Information Security Policy

Record Keeping and Records Management Policy

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.