

Data Quality Policy

The aim of this document is to identify the intentions of Leicestershire Partnership NHS Trust (LPT) in assuring the quality of information which supports its business. Specifically that is:

- Information that enables effective and timely communication regarding service users and their family/ carers, finances and staffing;
- Information upon which the Trust Board, directorates and stakeholders relies to monitor and/ or manage LPT's performance in all aspects of its business, including but not explicit to patient activity data, finance and staffing;
- Supports the delivery of public documents including, but not limited to Quality Account, national returns, annual statements etc.
- Supports and complies with the Information Governance Standard, information quality assurance, NHS Data Dictionary and information standard notices (ISN).

Key Words:	Data quality, information	
Version:	V.3.1	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	July 2020	
Name of Author:	Laura Hughes, Head of Information	
Name of responsible Committee:	Clinical Effectiveness Group	
Date issued for publication:	Confirmed after adoption by Policy Committee	
Review date:	July 2022	
Expiry date:	1 February 2023	
Target audience:	All staff	
Type of Policy	Clinical ✓	Non Clinical ✓
Which Relevant CQC Fundamental Standards?	Good governance	

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
V1.0	05/12/2017	New policy to reflect national guidance – information governance toolkit/ quality account/ NHS Improvement single oversight framework etc.
V2.0	01/02/2019	Section 5 – Duties within the organisation updated to include ‘validation’ techniques as recommended by 360 Assurance
V3.0	03/01/2020	Inclusion of data quality flag assessment Inclusion of Business Team responsibilities Update of policy names
V3.1	13/04/2020	Inclusion audit recommendations: - Information Team to respond to training requirements when requested (5.9)
V3.2	26/07/2020	Updated Head of Information contact details

For further information contact:

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (appendix 3) of this policy

Definitions that apply to this Policy:

AMH.LD	Adult Mental Health and Learning Disabilities
CDS	Commissioning Data Sets
CHS	Community Health Services
CQC	Care Quality Commission
DoH	Department of Health
DQ	Data Quality
DQIP	Data Quality Improvement Plan
Due Regard	<p>Having due regard for advancing equality involves:</p> <ul style="list-style-type: none"> - Removing or minimising disadvantages suffered by people due to their protected characteristics. - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. - Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
ETL	Extract Transform Load
FPC	Finance and Performance Committee
FYPC	Families Children and Young People's Services
HES	Hospital Episode Statistics
HIS	Health Informatics Service
HPA	Health Protection Agency
IAA	Information Asset Administrator
IAO	Information Asset Owner
IM&T	Information Management and Technology
IQPR	Integrated Quality Performance Report
ISN	Information Standards Notification
IT	Information Technology
KPI	Key Performance Indicators
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership NHS Trust
MDS	Minimum Data Set
POM	Patient Outcome Measure
QAC	Quality Assurance Committee
SDCS	Strategic Data Collection Services
SIRO	Senior Information Risk Owner
SLA	Service Level Agreement
SOP	Standard Operating Procedure/ Process
SUS	Secondary User Service

1 Purpose of the Policy

1.1 The aim of this document is to identify the intentions and outline the expectations of Leicestershire Partnership NHS Trust (LPT) staff in assuring the quality of information which supports its business.

1.2 Specifically that is:

- Information that enables effective and timely communication regarding service users and their family/ carers, finances and staffing;
- Information upon which the Trust Board, directorates and stakeholders relies to monitor and/ or manage LPT's performance in all aspects of its business, including but not explicit to patient activity data, finance and staffing;
- Information that supports and complies with the Information Governance Standard, information quality assurance, NHS Data Dictionary and information standard notices (ISN).

2 Summary and Key Points

2.1 All Leicestershire Partnership NHS Trust internal and published performance information will be subject to the same level of scrutiny.

- Those who collect and/ or record data are responsible for ensuring that it is of a known degree of accuracy through procedures, validation, training and monitoring;
- The responsibility is on individual teams and services to consider the adequacy of their own standard operating procedures (SOPs) for data collection and record keeping. If a significant risk is identified details should be recorded on the risk management system;
- Those who interpret and collate data are responsible for putting in place the necessary procedures, checks and approvals to ensure the reported information is correct;
- Those with executive responsibility for data are responsible for ensuring appropriate process are in place locally to assure them of data accuracy prior to authorising the release of any information externally.

3 Introduction

3.1 This policy and procedure is relevant to all staff including bank, agency and locum workers.

3.2 Data quality is a key part of any information system that exists within Leicestershire Partnership NHS Trust. All staff members will be in contact with a form of an information system, whether paper or electronic. As a result, all staff are responsible for implementing and maintaining data quality and are obligated to maintain accurate information legally (General Data Protection Regulation (EU) 2016/679 & Data Protection Act 2018), contractually (contract of employment) and ethically (professional codes of practice).

3.3 Systems include, but are not limited to:

- Electronic Patient Records –SystemOne

3.4 The purpose of the Data Quality Policy is to provide clear responsibilities for all

staff working within LPT to ensure individuals comply with the National Audit Commission's framework 'Standards for Better Quality Data'; and to provide a robust mechanism to provide assurance of best practices to support better data quality.

3.5 In the absence of universal standards for data quality, the Trust applies the principals of the six dimensions of data quality as described by the National Audit Commission:

Domain	Measure
Reliability	The Trust provides training, documentation and quick reference guides to support the use of clinical systems and the reliable entry of data. Refresher training and update training for new functionality is provided.
Validity	The Trust applies rules and methodologies as defined in the NHS Data Dictionary and other supporting national processes e.g. national access standards
Timeliness	The Trust has a standard for the timeliness of data entry for all its electronic patient systems as follows: <ul style="list-style-type: none"> • Inpatient based services: by the end of the shift • Community based services: within 24 hours of the event
Completeness	The Trust uses the data completeness metrics detailed by NHSI, these are: <ul style="list-style-type: none"> • Data quality maturity index (DQMI): identifiers (which monitors the completeness of core fields within the patient record, e.g. date of birth, GP, postcode etc.)
Accuracy	The Trust commissions annual audits to ensure clinical systems are being used correctly in line with national and local guidance; and that data is recorded. All information is authorised by the relevant executive (or delegated authority) prior to external release
Relevance	The Trust requires regular reviews of key performance indicators to ensure the relevance of reports in place

4 Flowchart/process chart

4.1 This chart shows the flow of data and the team/ role responsible for each point.

Key:

[DoS] [Director of Service](#)

[HoS] [Head of Service](#)

[SM] [Service Manager/ Team Lead](#)

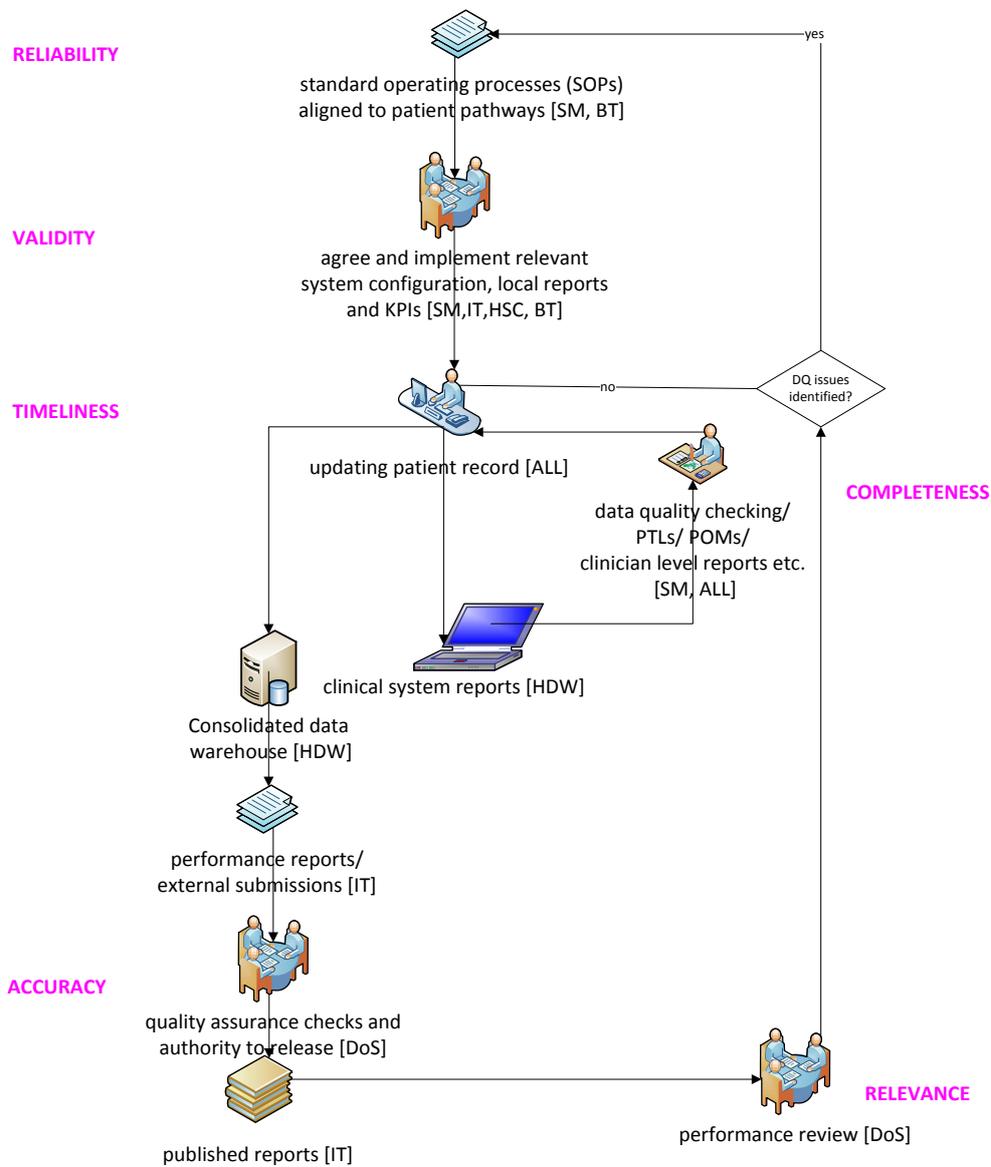
[BT] [Business Teams](#)

[ALL] [All Staff](#)

[IT] [Information Team](#)

[HSC] [HIS System Change Team](#)

[HDW] [HIS Data Warehouse Team](#)



5 Duties within the Organisation

5.1 The **Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2 The **Trust Policy Committee** is mandated on behalf of the Trust Board to adopt policies

5.3 **Trust Board Sub-committees** have the responsibility for agreeing policies and protocols.

5.4 **Directors of Services/ Information Asset Owners (IAO)** have the responsibility to:

- be accountable for the data which is recorded within their directorate. This will be achieved through formally establishing the 'Performance and Accountability Framework';
- ensure appropriate systems and processes are in place to provide assurance of **reliability, timeliness, completeness, accuracy** and **relevance** of data/ information;
- ensure all of their staff are fully aware of their obligations in these areas;
- provide authority to release information externally (this may be delegated to a named service head);
- manage performance for their area of accountability;
- manage associated risk(s) as appropriate.

5.5 **Heads of Service** have the responsibility to:

- ensure staff members are fully aware of and comply to the standard operational procedures (SOPs);
- ensure that competency in use of electronic systems features as an element of performance appraisal for relevant staff;
- ensure quality assurance processes (SOPs, PTLs, performance reviews etc.) are in place to assure the directorate of the quality of data and information used for external reports from a service perspective;
- ensure processes are in place to measure data quality using the data quality flag criteria on a minimum six-monthly basis. This can be via appraisals, clinical supervision, job planning etc.;
- manage/ escalate significant data quality risk as appropriate.

5.6 **Managers and Team Leaders** have the responsibility to:

- implement and regularly review standard operational procedures (SOPs);
- agree relevant system configuration, local reporting and KPIs for their service(s);
- review data quality reports and remove barriers to resolve issues in a timely fashion;
- implement data quality assurance processes (SOPs, PTLs, performance reviews etc.);
- implement data quality reviews with staff (appraisals, clinical supervision, job planning etc.);
- identify significant or emerging data quality risks and manage/ escalate these as appropriate.

5.7 **All Staff** have the responsibility to:

- follow locally agreed standard operating processes (SOP);
- record patient information into clinical systems in a timely manner;
- review data quality reports and resolve issues in a timely fashion;
- identify their own training needs;
- identify significant or emerging data quality risks and escalate these as appropriate.

5.8 **Business Team** have the responsibility to:

- support the development of standard operating processes (SOPs);
- support the design of KPIs and system configuration to meet the needs of the business;
- manage the implementation and performance management of directorate data quality improvement programmes.

5.9 **Information Team** (Corporate Service) have the responsibility to:

- review and update the data quality policy;
- provide expert advice to services on good data management practices;
- provide information training/ support as identified by staff;
- ensure that supporting reports relating to data quality are produced accurately and are accessible;
- agree and implement robust data/ report authorisation and release procedures;
- ensure externally shared data/ reports meets the requirements of trust information governance procedures;
- ensure the timely creation and submission of reports;
- highlight areas of poor data quality to the service for resolution;
- identify significant or emerging data quality risks and manage/ escalate these as appropriate;
- provide expert stakeholder advice and safeguard the integrity of trust data in the event of system change;
- ensure all changes required by external agencies for data provided by the trust are actioned in a timely and consistent manner (e.g. ISNs);
- ensure that information on changes in guidelines and data definitions is provided to the services and HIS for local procedures to be amended;
- manage audit programmes to establish the integrity of the clinical system data and report the results of those audits to relevant groups.

5.10 **HIS Systems Change Team** (Hosted Service) has the responsibility to:

- ensure systems are configured to accurately record clinical activity, to minimise manual actions and to minimise data quality issues;
- ensure systems are configured to meet national standards;
- provide clinical system training;
- ensure all requested changes follow the single clinical system change process and ensure changes are authorised by all relevant stakeholders prior to implementation;
- support the development of SOPs across the trust;
- Respond to requests from services to assist in the maintenance of data quality.

5.11 **HIS Data Warehouse Team** (Hosted Service) has the responsibility to:

- ensure all business rules are applied to data held in the warehouse;
- ensure the Trust's data and any other local/ national reference tables as required are migrated from clinical systems to our data warehouse where it is stored and processed optimally
- ensure data items are available on a daily basis;
- clearly communicate and resolve data failures, data loss and/ or data anomalies as part of the extract, transform and load (ETL) process in a timely manner;
- create clinical system reports to support data quality and operational management;
- create, maintain and support ad-hoc data collection tools/ systems in line with the HIS SLA.

5.12 **HIS Application Training Team** (Hosted Service) has the responsibility to:

- provide training on all clinical systems in line with the service needs;
- to manage the system change process

5.13 **Clinical Staff** have the responsibility to:

- Consent
 - Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.
- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;
 - Understand information about the decision
 - Remember that information
 - Use the information to make the decision
 - Communicate the decision

6 Overview of Process/ Procedure

6.1 Information is processed through seven key stages, each of which has procedures, checks and measures to ensure a high level data quality (see [flow diagram](#)):

- Standard Operating Processes (SOPs)
- System Change (optimisation)
- Data Input (Record Keeping)
- Data Validation
- Data Warehouse
- Information Delivery
- Performance Review, Authorisation and Submission

Standard Operating Processes (SOPs)

- 6.2 Standard operating processes (SOPs) are the service specific processes which clearly determine how and when information is entered onto clinical systems. SOPs assume staff have undertaken the mandatory clinical system training and are aligned to trust policies and processes, which set out the minimum Trust expectation. All services should be working to a SOP.
- 6.3 SOP implementation and maintenance is the responsibility of the service(s) they pertain to. Support for this process can be co-ordinated by business teams.
- 6.4 SOPs should be reviewed annually by the service as a minimum or as part of patient pathway/ service changes as well as during clinical system changes.
- 6.5 It is important SOPs are maintained and adhered to and fully reflects the patient pathway.

System Change (optimisation)

- 6.6 All requested changes to clinical systems must be made through the single change control process. These changes must be agreed by all relevant stakeholders prior to implementation and documented appropriately.
- 6.7 System changes must comply with national standards.

Data Entry

- 6.8 All staff entering data onto any clinical system must receive formal training before access is provided. User guides for clinical systems are available via the Trust intranet.
- 6.9 The minimum data entry quality requirements are set out below:
 - Staff must use standardised, rigorous searches on registration screens in order to identify patients accurately (including spine matching with the patient demographic service);
 - The Trust encourages services to promote patients to check and update their key demographic details for accurate recording on clinical systems at practicable interventions i.e. at each contact with the patient;
 - The patient NHS number, date of birth, gender, ethnicity, current address (including postcode) and GP practice must be recorded;
 - The Trust considers the most efficient way of maintaining quality patient records is to ensure that data items are correct at the point of recording:
 - Data collected is reviewed at the time of first contact with the patient to ensure that all core data items are accurately recorded. Information must be validated with the patient at the first and subsequent contacts.
 - This should be done as soon as possible after the patient is seen or when the procedure is complete - This should be no later than the end of the shift on inpatient areas; or no later than 24 hours after the event in community based services.
 - Where data is recorded inaccurately or incompletely, it is the responsibility of the service recording the data to make corrections. Where possible this should be completed by the individual responsible. This extends to data which has been recorded incorrectly in the past where retrospective

correction is appropriate and required;

- Where on-going and regular issues with data collection are identified, these should be fed into the development of training/ update programmes and escalated as a risk as appropriate.

Data Validation

6.10 All staff entering data are responsible for the quality of the information they enter onto clinical systems.

6.11 Services are required to implement and enforce robust data validation processes to ensure the quality of data held in clinical systems. These include but are not limited to:

- weekly patient tracking lists,
- weekly caseload cleansing,
- weekly patient outcome measure (POM) reviews,
- annual record keeping audits etc.

6.12 Wherever possible, reports for data validation should be extracted directly from the clinical system.

6.13 Issues relating to any of the six domains of data quality should be recorded and action taken locally to resolve. Local support for actions can be sought from the directorate Business Manager, Business Information Manager, Clinical Safety Officer (CSO) and LHM Change Manager. Actions which cannot be resolved locally should be escalated to the Head of Service.

6.14 If the issue affects the performance of a national or contractual KPI, the Head of Service should flag this with the Head of Information immediately. The Head of Information is responsible for assessing the risk from a Trust performance perspective and escalating to the Senior Information Risk Officer (SIRO) as necessary.

Data Warehouse

6.15 The data warehouse provides a single source of patient information and activity by consolidating information from all the trust's clinical systems.

6.16 The data warehouse **should** be used for management and performance reporting.

6.17 The data warehouse **should not** be used for operational or clinical decision making.

Information Delivery

6.18 All regular reports will be supported by a technical standard operating processes (SOP), which clearly determines how and when information is extracted from the data warehouse (or otherwise) and is used to populate reports.

6.19 Known technical issues affecting performance will be clearly defined in the reports.

Performance Review, Authorisation and Submission

6.20 Services are required to quality assure the management and performance reports provided to them. The performance review should consider both the operational performance of the service as well as the quality of the data from which the performance measure is derived.

6.21 The quality of the data will be measured using the **data quality flag assessment** (available on staff intranet) at a minimum frequency of six months to determine whether the Head of Service is assured the service has confirmed and challenged the information robustly through the data validation process. Services should clearly describe any issues identified during the earlier data validation processes on the report to caveat any anomalies.

6.22 Directors of Services are required to authorise the release of information to external/ public bodies including but not limited to trust board, commissioners, NHS Digital, CQC etc. Information shall not be released externally unless it has received explicit consent to do so.

6.23 This authorisation will confirm that the relevant authority has deemed the information reported to be (see [introduction](#) for details):

- Reliable
- Valid
- Timely
- Complete
- Accurate
- Relevant

6.24 Consideration should be taken to caveat/ pause submission of national reports where significant data quality issues have been escalated to the SIRO. Agreements to caveat or pause national submissions must be endorsed by the Finance and Performance Committee (FPC) and noted at Trust Board.

7 Education and Training in Information Quality

7.1 Achieving and maintaining good data quality requires on-going education and training throughout LPT. No staff members must be able to use or enter data onto key patient information systems, without adequate training. This includes temporary, locum and clinical staff.

7.2 The training programme must cover all aspects of information quality required:

- The definition of individual data items - so staff know what they are recording;
- The function of data – so staff know why they are recording data;
- How to validate data with the patient or against the records – so staff are recording the correct data;
- The correction of errors – so staff know how to correct errors and how to report errors if they find them;
- The eventual use of data – so staff understand what the data they are recording will eventually to be used for and therefore why it is important to get right.

7.3 All staff should receive training and awareness sessions to ensure that they understand the importance of accurate patient identification to minimise clinical and organisational risk. As a minimum, the combination of LHS clinical system training and the service specific Standard Operating Process (SOP) will cover these requirements.

8 Collection and Use of the NHS Number

8.1 The NHS Number is the mandated national unique identifier for patients and must be used alongside other demographic information to identify and link the correct records to a particular patient.

8.2 Everyone registered with the NHS in England and Wales has their own unique NHS Number. Patients who have not registered with a GP practice will not have a number. Overseas visitors may have been issued with a temporary number and people who are not eligible for free NHS treatment can have an NHS Number. Babies born in England and Wales are issued with NHS Numbers soon after birth. All correspondence, both paper and electronic, must include the NHS Number

8.3 Frontline staff must ensure the NHS number is collected at the earliest contact of the patient with the trust. Every effort must be made to improve completeness and accuracy through real-time and on-going tracing and validation.

8.4 Batch tracing of NHS numbers will be undertaken by HIS to maximise the coverage of NHS Numbers in the patient master index for patients who have recently attended the trust. Resulting data quality reports are followed up by the front line staff to ensure that completion is as high as practically possible.

9 National Data Sets

9.1 LPT is required to submit national data sets for mental health (MHSDS), community services (CSDS) and Commissioning Data Sets (CDS) to the Secondary Uses Service (SUS) to:

- Provide data at patient level to commissioners of activity;
- Fulfil the requirement for compilation of Hospital Episode Statistics (HES) by the Department of Health (DoH);
- To meet data quality standards included within the Care Quality Commission Health check – e.g. coverage of ethnicity data and the quality of maternity and births data.

10 Data Pseudonymisation and Anonymisation

10.1 Patient identifiers such as name and address are required to be removed from CDS when the patient's NHS Number is present. The Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 impose statutory restrictions on the disclosure of information about identifiable individuals in connection with certain infertility treatments. The trust therefore omits all patient identifiers from CDS where required, and also where it has additionally chosen to do so.

11 Training needs

There is no training requirement identified within this policy

12 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
Section 5	Meeting the national quality standards for data completeness	Services are collecting and recording appropriate patient information on the clinical information systems	Data quality feedback scores against national submissions	Finance and Performance Committee	Monthly
Section 5	Annual audit as agreed by Trust	Audit outcomes	Audit outcomes	Information asset owner (IAO)	Annually

13 Standards/ Performance Indicators

Target/ Standards	Key Performance Indicator
NHS Oversight Framework (OF) Data Quality Maturity Index (DQMI) – mental health dataset score	>= 95%

14 References and Bibliography

14.1 This policy was drafted with reference to the following:

- National Audit Commission's framework 'Standards for Better Quality Data' (Nov-2007)
Retrieved from:
<https://webarchive.nationalarchives.gov.uk/20080806164253/http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/AE298947-73F0-4dcb-AF77-D2520EECBCFB/ImprovingInformationToSupportDecisionMaking.pdf>
- NHS Oversight Framework (23-Aug-2019)
Retrieved from:
<https://improvement.nhs.uk/resources/nhs-oversight-framework-201920/>

14.2 This policy was drafted with reference to the following policies:

- Data Protection and Information Sharing Policy (29-Jun-2018)
- Information Lifecycle and Records Management Policy
- Record Keeping and Care Planning Policy (17-May-2018)
- Data Security and Protection Framework (17-Dec-2018)
- Patient Information Policy (01-Nov-2019)

14.3 The following policies and procedures are available for further support:

- Access to Treatment Policy
- Performance and Accountability Framework
- Service level Standard Operating Procedures
- Data Protection, Caldicott and Confidentiality Policy
- Information Governance Strategic Management Framework

Appendix 1

The NHS Constitution

Complete the checklist in order to provide evidence that you have considered the principles of the NHS Constitution. For further details please refer to the Development of Procedural Documents Policy.

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	<input type="checkbox"/>
Respond to different needs of different sectors of the population	<input type="checkbox"/>
Work continuously to improve quality services and to minimise errors	<input checked="" type="checkbox"/>
Support and value its staff	<input type="checkbox"/>
Work together with others to ensure a seamless service for patients	<input checked="" type="checkbox"/>
Help keep people healthy and work to reduce health inequalities	<input type="checkbox"/>
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	<input checked="" type="checkbox"/>

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Laura Hughes	Head of Information
Vicki Quinn	Head of Business Development - CHS
Samantha Wood	Business Manager – AMH.LD
Zayba Joondan	Business Manager – AMH.LD
Julia Bolton	Business Manager – FYPC

Circulated to the following individuals for comment

Name	Designation
Girish Kunigiri	Chief Clinical Information Officer
Dani Cecchini	Senior Information Risk Officer
Sam Kirkland	Head of Information Governance
Kate Dyer	Head of Quality Governance
Noel O’Kelly	Chair of CHS Data Quality Improvement Plan Group
Fabida Noushad	Chair of AMH.LD Data Quality Group
IM&T Delivery Group	Group includes (in addition to the above): Clinical Safety Officers, Head of LHS, LHS Programme and Change Manager

Due Regard Screening Template

Section 1			
Name of activity/proposal		Data Quality Policy	
Date Screening commenced		December 2019	
Directorate / Service carrying out the assessment		Information Service	
Name and role of person undertaking this Due Regard (Equality Analysis)		Laura Hughes – Head of Information	
Give an overview of the aims, objectives and purpose of the proposal:			
AIMS:			
The aim of this document is to identify the intentions of Leicestershire Partnership NHS Trust (LPT) in assuring the quality of information which supports its business. Specifically that is:			
<ul style="list-style-type: none"> Information that enables effective and timely communication regarding patients and care; Information upon which the Board relies to monitor and manage LPT's performance in all aspects of its business which is included in the performance reports. 			
OBJECTIVES:			
To improve and monitor clinical system data quality			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	No impact		
Disability	No impact		
Gender reassignment	No impact		
Marriage & Civil Partnership	No impact		
Pregnancy & Maternity	No impact		
Race	No impact		
Religion and Belief	No impact		
Sex	No impact		
Sexual Orientation	No impact		
Other equality groups?	No impact		
Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No <input checked="" type="checkbox"/>	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This is a neutral policy with no positive/ negative impact on any specific group			
Signed by reviewer/assessor	Laura Hughes	Date	27/12/2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Laura Hughes	Date	27/12/2019

Data Privacy Impact Assessment

Name of Document:	Data Quality Policy		
Completed by:	Laura Hughes		
Job title	Head of Information	Date 27/12/19	
Screening Questions	Yes / No	Explanatory Note	
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No		
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No		
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No		
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No		
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No		
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No		
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No		
8. Will the process require you to contact individuals in ways which they may find intrusive?	No		
<p>If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</p>			
Data Privacy approval name:	Laura Hughes		
Date of approval	27/12/2019		