South East Coast Ambulance Service NHS
NHS Foundation Trust

Data Quality Policy

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1 Introduction

1.1. South East Coast Ambulance Service NHS Foundation Trust ('the Trust') is committed to upholding the principles of effective record management. To this end all records will be completed accurately, be easily accessible and up to date. The purpose of this document is to outline the high-level principles that collectively come together to form the Trust's Data Quality Policy.

2 Aims and Objectives

2.1. The principles contained within this policy will provide a framework for Information Asset Owners (IAO), which will facilitate the development of departmental data quality procedures to ensure that data held is accurate, fit for purpose and available when required.

2.2. This policy is complemented by a number of information governance policies that support sound records management and data quality principles.

3 Definitions

- **Accuracy:** accurate data should be captured at the point of activity, captured only once although it may have multiple uses and verified via a series of checks.
- **Validity:** data should be recorded and used in compliance with relevant requirements and definitions.
- **Reliability:** data should be collected in a stable and consistent way across collection points and over time.
- **Timeliness:** data will be available quickly and frequently.
- **Relevance:** data will be relevant to the purpose for which it is used and should be reviewed periodically to ensure that it reflects changing needs
- **Completeness:** the data should include all relevant records otherwise accuracy is compromised.

4 Policy Statement

4.1. The Trust recognises the importance of reliable information to the delivery of patient care. Data Quality is crucial, and the availability of complete, accurate and timely data is important in supporting patient care, clinical governance, corporate governance, Information governance and the management and service level

agreements for healthcare planning and accountability. This policy will ensure full compliance in all these areas.

5 Arrangements

5.1. The arrangements for Data Quality processes are devolved (due to the often specialist nature of the data) to those staff responsible for management of their Directorate/ Department data. Guidance and advice will be provided by the Head of Information Governance / IG Manager with support from the Trust SIRO and Caldicott Guardian to ensure compliance with this policy.

5.2. Within the Trust data will be validated using the following methods:

5.2.1. **Manual**

- At the point of collection, staff must validate the data they collect from patients.
- Clinical audit information produced for reporting purposes must ensure the data is validated for accuracy and consistency.
- Monitoring will be undertaken six monthly by the Head of Information Governance / Information Governance Manager with support from the Trust SIRO to ensure compliance.
- Reports of non-compliance will be reported to the Information Governance Working Group (IGWG), which is chaired by the Trust SIRO for any additional remedial actions.

5.2.2. **Computerised**

- Many of the Trust's systems have inbuilt 'logical checking programmes'. These ensure illogical data cannot be input onto a system.
- The Head of Information Governance / Information Governance Manager will undertake relevant system audits to ensure compliance. Any non-compliance issues will be reported to the (Head of IT) and Trust SIRO for any additional remedial actions.

5.2.3. **Improving Data Quality**

- The drive to improve and maintain the quality of the Trust's patient related data is underpinned by a range of initiatives:
  - Regular validation of the patient care record at point of submission.

- Production of data quality reports to maintain and collect missing data items and errors on a regular basis.
- Monitoring of data quality reports produced.
- Attendance at local information forums to share local and national issues concerning the collection, recording and submission of patient related data.
- Use of the National Strategic Tracing Service (NSTS) to capture accurate NHS Number details through batch and on-line facilities.
- Achievement of the Trust's Information Security Agenda.

- Non-clinical data is processed in accordance with the Trust's Records Management Policy.

6 Responsibilities

6.1. Within the Trust, roles and responsibility for Data Quality have been allocated as follows:

- The Trust SIRO has Board level responsibility for data quality (delegated authority of the Chief Executive).
- Within the Quality & Nursing Directorate the functional responsibility for Data Quality is delegated to the Head of Information Governance.
- The Head of Information Governance is responsible for monitoring the day-to-day management of data quality in respect of electronic and paper records, ensuring the importance of data quality is notified throughout the Trust.
- The IAO's of information systems within the Trust are responsible for developing appropriate procedures to ensure the accuracy of the data held within their systems and timeliness of necessary corrections to that data. Appointed IAO's are now in place across all Directorates and are aware of their roles and responsibilities.
- It is the responsibility of all staff who manage data to ensure it is of the highest quality at the point of capture.
- The IG Working Group will monitor the effectiveness of the corrective actions implemented where non-conformity has been identified.

7 Competence

7.1. Training and Development of staff is key to the achievement of high levels of data quality. The following principles should be met to achieve this:

- All new staff that are to use any Information Systems will receive appropriate training in the use of the respective systems from their line managers. Including the completion of mandatory Information Governance training relevant to the role, and as included in the Trusts overarching IG Training Needs Assessment.

- Access to these systems will only be granted once training has been completed to the satisfaction of the line manager.

8 Monitoring

8.1. All electronic and paper records will be the responsibility of the IAO's. Checks will be carried out on all documents submitted for inclusion in the Records Database / Corestream electronic Information Asset Register. Any non-conformity will be returned to the author for corrective action.

8.2. The Head of Information Governance / Information Governance Manager will provide monitoring reports for submission to the IG Working Group. A review of the Information Asset Register will take place every six months.

8.3. A two-stage validation process will be put in place to ensure data quality and timely information:

- Emergency Operational Centres (EOC's) Information Management will identify (using the agreed Data Validation procedures) on a daily basis activity and response data that requires validation.

- EOC's will undertake a review of the data and amend where appropriate prior to importing the data to the SECAmb data-warehouse.

8.4. The Head of Information Governance will report any non-conformance brought to its attention to the IG Working Group for information purposes only; highlighting the corrective action utilised to correct the non-conformance.

9 Audit and Review

9.1. All documents are to be reviewed annually in line with the Records Management Policy unless it becomes necessary to bring forward this activity to rectify any serious non-conformity.

9.2. The Head of Information Governance / Information Governance Manager will carry out 2 annual checks on all submitted documents to ensure compliance. This involves a review of Corestream electronic Information Asset Register twice a year

9.3. The IG Working Group will audit the areas allocated to them under this policy. This is underpinned by the Trust SIRO and Chair of this working group.

9.4. All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

9.5. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

9.6. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

9.7. All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

10 Equality Impact Appraisal

10.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

10.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature, then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those function.

11 References

- NHSx Records Management Code of Practice 2021