Trust-wide Document

Great Western Hospitals
NHS Foundation Trust

Data Quality Policy

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Approved by	Policy Governance Group	**Date Approved**	04/04/17
Ratified by	Information Governance Steering Group	**Date Ratified**	05/05/17
Date implemented (made live for use)		**Next Review Date**	05/05/20
Status	LIVE		
Target Audience- who does the document apply to and who should be using it.	All employees directly employed by the Trust, whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
Accountable Director	Director of Finance		
Author/originator – Any Comments on this document should be addressed to the author	Head of Informatics		
Division and Department	Corporate - Informatics		
Implementation Lead	Head of Informatics/Head of Access		
If developed in partnership with another agency ratification details of the relevant agency	N/A		

Equality Impact
Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

Special Cases

There are no special cases where this policy does not apply.

Contents

1 Instant Information – Everyone is Personally Responsible for the Quality of Data that they complete whether electronically or on Paper

All employees are **personally responsible** for the quality of data entered by themselves, or on their behalf, on the Trust's computerised systems. Whether held on paper or electronically, employees have a responsibility to ensure that the data is accurate, timely, and as complete as possible.

This responsibility will be clarified in the employee's job description and their professional body such as the General Medical Council, Nursing and Midwifery Council, Health and Care Professions Council (etc. and monitored via ongoing supervision/appraisal. It is essential that any alterations or updated information is amended as soon as possible on the Patient Information Systems to provide up-to-date information to support the delivery of care and to meet statutory requirements, e.g. Information Governance data-quality standards.

2 Document Details

2.1 Introduction and Purpose of the Document

Ever increasing use of computer based systems provides greater opportunities to store and access many types of data. In the healthcare setting this is not only increasingly useful for the treatment of an individual patient, but provides greater opportunities to analyse aggregate data to inform and advance future treatment programmes.

All trusts send patient data to various national databases including Hospital Episode Statistics (HES), commissioners (e.g. Clinical Commissioning Groups – (CCGs)) and other organisations via the Secondary Uses Service (SUS), and other direct data transmissions, so data has a wider audience than just within the originating organisation.

The Department of Health (DH) has for a number of years placed requirements on foundation trusts to ensure that they hold good quality data and has required trusts to have in place processes and procedures to provide assurances to themselves, as well as external users of their data, that their information is of high quality.

Data quality is fundamental to the performance monitoring of Great Western Hospitals NHS Foundation Trust (the Trust) by the DH, the Care Quality Commission (CQC), Monitor and other monitoring bodies, as well as access to performance fund monies, and feeding into DH interventions. Data therefore needs to be accurate, correct, current, complete and relevant.

Without timely access to accurate data, the National Health Service (NHS) will not be able to account for activity performed, ensure provider payments are accurate, or indeed commission the right services.

This document summarises the actions that are to be taken by all employees to ensure data quality is achieved and maintained and the procedures that the Trust Informatics Department is to follow consistently when monitoring the quality and completeness of patient activity data held on Trust systems. This includes actions, such as reviewing and correcting data, ensuring completeness and validity of data, to ensure data quality is maintained.

Good quality data is a fundamental requirement for the speedy and effective treatment of patients. Management information produced from patient data is essential for the efficient running of the Trust and to maximise utilisation of resources for the benefit of patients and employees. The adoption of a Data Quality Policy reinforces the Trusts commitment to effective and efficient patient care and helps to meet patient’s expectations that data held about them is accurate.

The Trust strives to achieve high quality data at all times and maintain methods to ensure that the quality is consistent and right the first time. High quality means:

- Complete.
- Accurate.
- Up to date.
- Free from duplication.
- Free from confusion.

The procedures in this document summarise the data quality monitoring and testing that are to be undertaken by the Trust Informatics Department on the main corporate patient activity systems in the Trust to ensure that data quality and completeness levels meet the standards required.

2.2 Glossary/Definitions

The following terms and acronyms are used within the document:

%	Percentage
CCGs	Clinical Commissioning Groups
CDS	Commissioning Data Set
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
DH	Department of Health
DNA	Did not attend
DQR	Data Quality Reports
ED	Emergency Department
EPR	Electronic Patient Record
GP	General Practitioner
GWH	Great Western Hospitals NHS Foundation Trust
HES	Hospital Episode Statistics
HRG	Healthcare Resource Groups
ICIS	Integrated Clinical Information Systems
IG	Information Governance
IGSG	Information Governance Steering Group
IM&T	Information Management & Technology
IT	Information Technology
Medway	Acute Trust Patient Administration System
MIU	Minor Injury Unit
NHS	National Health Service
PAS	Patient Administration System (including Medway and SystemOne)
PbR	Payment by Results
RTT	Referral to Treatment
SLAM	Service Level Agreement Monitoring
SUS	Secondary Uses Service

3 Main Policy Content Details

3.1 Data Quality Standards

The Trust aims to address the following domains of good quality data including:

3.1.1 Validity (Precision)

All data items held on Trust computer systems must be valid so that where codes are used, these must comply with national standards or map to national values. Wherever possible, computer systems must be programmed to accept only valid entries.

3.1.2 Completeness (Relevancy)

All mandatory data items within a data set must be completed. Use of default codes must only be used in accordance with procedures and national guidelines and not as a substitute for real data. If it is necessary to bypass a data item in order to admit that patient, the missing data must be reported for immediate follow up.

3.1.3 Consistency

Data items must be internally consistent. For example, patients with multiple episodes or contacts must have coherent dates. Procedures and diagnoses must be recorded in accordance with information known to be appropriate to the patient.

3.1.4 Coverage (comprehensiveness)

Data must reflect all of the patient related work done by the Trust. For example admissions, outpatient and Emergency Department (ED) attendances, operations and procedures and contacts must all be recorded. Correct procedures are essential to ensure complete data capture. Spot checks and comparisons between systems must be used to identify missing data.

3.1.5 Accuracy

Data recorded on paper and on computer systems must accurately reflect what actually happened to a patient.

Manual data must be written legibly and be signed and dated where appropriate.

All reference tables, such as General Practitioners (GP) Surgeries and postcodes, must be updated regularly by system managers. This must be within a month of publication unless there are serious doubts about the quality of the data supplied.

Every opportunity must be taken to check patients’ demographic details with the patients themselves. Inaccurate demographics may result in important letters being misdirected, incorrect identification of a patient, or inability to identify an NHS Number.

3.1.6 Timeliness

Timely recording of data is beneficial to the treatment of the patient. Putting results of tests into the computer, or recording diagnoses and operations makes that information available to all treating the patient, even if they do not have access to the paper notes.

All data must be recorded in real time or as near as possible to the event, for data that is time constrained such as clinical coding, this must be complete before any deadlines that are dependent on this information such as reporting to commissioners.

Any issues or delays in data entry should be reported to the line manager or head of service, to allow any mitigating action to be taken.

The accurate recording of data items must not be allowed to delay urgent treatment of a patient. Operational procedures must ensure that information flows from clinical employees to clerical employees within agreed deadlines.

3.1.7 Accessibility

The Trust must ensure that data items are easily accessible, and that strong protections and controls are built into the process. For example, access controls based on the user's job role and need to access certain information.

3.1.8 Currency (up to date)

The extent to which data is up-to-date; a datum value is up-to-date if it is current for a specific point in time. It is outdated if it was current at a preceding time yet incorrect at a later time.

All data must be recorded within specified deadlines; best practice dictates that data entry should take place at, or as near as possible to, the event being recorded. This will ensure that up to date data can be included in national, local and internal reports.

3.1.9 Data Definitions

The specific meaning of a healthcare related data element.

3.1.10 Granularity

The level of detail at which the attributes and values of healthcare data are defined.

3.2 Data Quality Checks

The following section describes the data quality and completeness checks that will be applied to main Trust systems. There should also be an element of cross checking between systems that should contain the same information.

3.2.1 Routine Reporting of Data Completeness

The Informatics Department are to produce, at least monthly, summary reports showing aggregated volumes of data by month and the completeness of key data items with valid codes (e.g. outpatient outcome, ethnicity) as assurance that expected levels of activity and completeness are being maintained on Trust systems. Reports are to be made available to System Managers, relevant Trust managers and the Data Quality Steering Group.

3.2.2 External Data Quality Reports

All external reports and audits covering data quality issues relating to Trust corporate systems are to be monitored by and reported to the Trust Data Quality Steering Group when received by the Trust and actions allocated to the relevant system manager or lead and tracked via the Data Quality Steering Group. Examples include the monthly data quality report produced by the SUS covering Admitted, Outpatient and ED Attendances and Clinical Coding Audits.

3.2.3 Data Quality Validation and Trust Data Warehouse

The development of the Trust data warehouse has allowed the development of data quality and completeness tests as data is loaded and this is being extended to all corporate data as it is merged onto the warehouse. Any issues that require data correction on source systems are fed back to the relevant system managers.

The loading of data on a daily basis for several data sets allows data quality reports to be produced daily for system managers and these reports will be made available through reporting mechanisms. Examples include missing outpatient outcomes, missing ethnicity, did not attends (DNAs) and reports will continue to be developed.

3.2.4 Accuracy Checks Complying with Information Governance Toolkit

The Information Governance (IG) Toolkit (Ref 1) has prescribed patient level tests for Admitted and Outpatient Episodes which require the Informatics Department to take a sample of activity and validate at patient level to ensure several key data items are present and comply with the NHS Data Dictionary definitions. This is known as a completeness and validity check of data which must be completed and passed and a report produced as evidence for the IG Toolkit. The Trust Information Manager is to undertake these tests on a quarterly basis for the IG Toolkit.

Clinical Coding is externally audited on an annual basis to meet the requirements of the IG Toolkit as well as having an external Payment by Results (PbR) audit carried out by the Audit Commission. A regular programme of internal audit is undertaken by the Trust Clinical Coding Manager and reported to the Trust Data Quality Steering Group.

3.3 Documented Procedures

Careful monitoring and error correction can achieve good quality data, but it is more effective and efficient for data to be entered correctly the first time. In order to achieve this, procedures must exist so that employees can be trained and supported in their work.

As a minimum, the following procedures must be documented:

- Registering a patient.
- GP referral to outpatient clinic, service or test.
- Attendance, cancellation, DNA, outcome at outpatient clinic or visit.
- Add and remove patient to waiting lists.
- Emergency or elective admission, transfer and discharges.
- Attendance at ED and Minor Injury Units (MIU)
- Status update, linkage and closure of referral to treatment episodes (RTTs).

3.4 Training

Appropriately designated employees must train all users of computer systems. Training sessions must cover functionality and usage of systems but also inform the importance of accurate data and responsibility of the use to ensure that.

On issue of passwords, users must sign not only a confidentiality clause but also an undertaking to take reasonable steps to ensure the accuracy of information that they enter on the computer system. This is in line with the Trust’s Data Protection Policy (Ref 2).

Supervisors must ensure that all users of computer systems have:

- Appropriate initial and refresher training (this is usually provided by the Trust’s Information Technology (IT) Department.
- Access to appropriate and up-to-date documentation e.g. quick reference guides to data input.

All major data entry systems must have an audit trail that will be turned on and used to identify individuals requiring training. Sufficient computer resources must be available for logs to be held for an adequate period of time.

Employee retraining must be offered as required. If persistent errors, this may lead to the removal of logins/passwords, until such time as the user can demonstrate competency in the use of the computer system(s).

3.5 Identifying and Correcting Errors

Errors must be identified as close to the point of entry as possible. Actions to support correction and avoidance of errors are:

1. Routine reports from Patient Administration System (PAS) or other systems. For example:

    - Partial registration.
    - Missing outcomes of attendance.
    - Clinical coding.
    - Missing NHS Numbers.

2. A suite of daily, weekly and monthly error reports available for services to monitor and resolve quality issues.

3. Investigation of external Data Quality reports, such as the SUS Data Quality Dashboards and Commissioner data quality reports, by the Trusts Data Quality Steering Group.

4. Where feasible Information Systems and processes are to have routines developed and designed to systematically identify errors and other aspects of poor data quality.

All identified errors must proceed to be correct by the relevant employees. This can be supported by the Clinical Application Team using the audit trail to identify areas of difficulty, so that training or other action can be taken

3.6 Measurement of Good Data Quality

3.6.1 Internally

The Information Manager must submit monitoring reports monthly to the Trust's Data Quality Steering Group and on at least a quarterly basis to the IG Steering Group (IGSG). These reports must include data items, which have been identified as causing concern. For example, coding completeness and validity, coverage of NHS numbers, ethnic group, outpatient outcomes, review of external audit reports etc. They are also to be used to inform management, to improve processes, training, documentation, and computer systems. Feedback must be given to users and must be tracked by the Trust's Data Quality Steering Group.

3.6.2 Externally

The Trust is to:

- Aim to be significantly above average in all data quality and data coverage indicators measured and monitored in external reports (example below) and will strive for 100% accuracy four weeks following quarter end.
- Act on all enquiries and complaints from commissioners or patients.

Examples of external monitoring reports sources are:

- Data Quality dashboards and reports from SUS.
- HES Data Quality Indicators, Check-in and Auto-clean reports.
- Data Quality Summary on Dr Foster.
- Queries from commissioners.
- Case note audit.
- Information Governance Toolkit.
- Audit commission audits.

3.7 New Patient Services

Any proposals for new patient services or changes made to existing services, need to be given to IT and Informatics Departments in order that:

- Arrangements can be made to collect any relevant activity and ensure this complies with NHS National Standards Data Definitions,
- Risks to systems such as Medway (PAS) or other Patient Administration Systems are eliminated or minimised.
- Training requirements are assessed.

It is important that this information is provided before the introduction of any new service or proposed change to an existing service.

Details of any new services or proposed changes to existing services must be forwarded to the IT Service Desk (IT.ServiceDesk@gwh.nhs.uk), who will then pass on details on to relevant employees:

- IT and Projects Manager.
- Head of Informatics.

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Director of Finance

Management of data quality will be within the remit of the Director of Finance.

4.3 Specific Team Responsibilities

There will be posts within the PAS Supplier team, Informatics Department, Clinical Coding, Health Records, IT and clinical divisions with responsibility for data quality issues in their areas.

4.4 System Managers

All computer system managers will be responsible for supporting and ensure good quality of the data within their system.

4.5 Line Managers

All managers have a responsibility to ensure that their employees are aware of their responsibilities relating to data quality, receive adequate training, have access to up to date procedure documents, and correct errors where identified.

4.6 All Employees (Target Audience)

All employees are **personally responsible** for the quality of data entered by themselves, or on their behalf, on the Trust's computerised systems. Whether held on paper or electronically, employees have a responsibility to ensure that the data is accurate, timely, and as complete as possible.

This responsibility will be clarified in the employee's job description and monitored via ongoing supervision/appraisal. It is essential that any alterations or updated information is amended as soon as possible on the Patient Information Systems to provide up-to-date information to support the delivery of care and to meet statutory requirements, e.g. Information Governance data-quality standards.

4.7 Human Resources

The Human Resources Team will provide details and dates for 'New Starters' to the organisation. Using this information, the IT Training Team will arrange relevant training for the individual within the first week of their employment where possible. This training will be arranged based on their Job role, which will be authorised by the new starter's line manager. Community services employees are also trained under the same protocol as acute employees.

It is the responsibility of line managers/supervisors to request Skills Training where they feel their new starters may benefit from this; however this training may also be requested at any time by any employee.

Where possible, managers who are recruiting temporary workers, agency, bank workers or locums, should give as much notice as possible to the IT Training Team, so that appropriate training can be arranged. The training team will not be responsible for employees that cannot perform required duties in the event that insufficient notice is given to arrange training.

Duty Managers have access to accounts for some clinical systems that can be used in emergency situations. These accounts have to be signed for and are logged on the appropriate systems.

4.8 Assistant Directors of Operations, Divisional Directors, Ward Managers and Supervisors

All managers (as above) are responsible for ensuring employees within their areas of responsibility are appropriately trained and monitored to comply with this policy.

Individual employees are responsible for entering data in a timely, accurate and secure way and ensuring errors are dealt with in a timely manner and resolved or escalated where appropriate.

Each individual has a duty to be able to understand the systems, how to use them effectively and maintain their knowledge and competency. If individuals have any specific requirements then these should be discussed with their line manager in order to ensure that they receive appropriate access and support.

Each employee will undergo training on the Trust's IT systems before being allocated a Smart card or user account to access them.

Each Division will ensure that they always have a Data Quality representative who will attend the Data Quality Steering Group, feeding back any data- quality issues to their employees, colleagues and managers.

The management of data quality issues is undertaken at divisional level. Significant or systematic deficits will be dealt with and an appropriate course of action taken to remedy them, ensuring employees making errors attend for re-training and, if required, individuals not complying with the correct use of the system, or making repeated errors after re-training, may be managed under the Trust's Improving Performance Policy (Ref. 4).

4.9 Data Quality Team

The Data Quality Lead within the Informatics Department is responsible for co-ordinating and disseminating data-quality issues and ensuring KPIs are monitored on an ongoing basis.

The role of the Data Quality Lead is to ensure a range of agreed monitoring reports are in place and are readily available to users. The Data Quality Lead will provide advice and guidance on data-quality standards.

The Data Quality Lead will monitor a range of data quality indicators as agreed by the Data Quality Steering Group ensuring errors are resolved within the required timescales, providing error reports to each Division and feeding back on progress.

4.10 Information Team

The Informatics Commissioning Analyst will be responsible for locating missing data via the commissioning query process and ensuring that queries are investigated, resolved, corrected at source and the results are feedback to commissioners.

The Informatics Department will support and investigate data-quality queries which are received from commissioners, with assistance from divisional teams and the Contracts Team. Complex data-quality issues will be passed to the IT Training Team who will visit users to assist them in correction of the errors and train them how to avoid subsequent errors.

The Informatics Department will ensure Commissioning Data Set (CDS) data is submitted to Secondary Uses Service (SUS) at least monthly, on-time and complete. A record of CDS submissions will be kept and the timetable adhered to. Data will be refreshed routinely to fit in with the flex –and-freeze timetable.

4.11 IT Training Team

The IT Training Team run induction sessions for all new employees to cover IT usage, skills and processes. Generic IT questions will also be answered where possible, with delegates being referred to the appropriate department where necessary.

When new features of a system are introduced, relevant documentation, appropriate communication and/or training will be arranged by the IT Training Team as required.

The IT Training Team has access to a fully equipped training room where the majority of systems and applications training takes place. This room is available for training use by other Trust departments, subject to the agreement of the IT Training Manager. Dependent on the software, systems or processes being trained, this may take place elsewhere within the Trust as appropriate, and with the recipient's agreement.

Where possible, trainers will attempt to support users in their place of work to make refresher training/support as relevant as possible.

Where capability issues in system use exist, employees should be booked on to refresher training. There is no need for those who are proficient in using systems to attend refresher training. This can be requested by employees or their managers.

The IT Training Team will provide support to employees as necessary, however in conjunction with the Data Quality Lead (and departmental managers in some cases), the Training Team may determine employees as ‘un-trainable’. This decision would only be taken as a last resort, to protect and maintain system integrity and data quality.

Access and/or Smartcards may be revoked once the employee’s manager has been notified, and only returned once sufficient standards have been met. Failure to meet these standards may invoke the Trust’s Performance Management Policy (Ref 4).

4.12 Responsibilities for Data Quality Reporting and Auditing

4.12.1 Head of Informatics

The Head of Informatics is to ensure data quality compliance is reported to and monitored by the Trust Data Quality Steering Group and System Managers. They are to also ensure mandatory audits and data quality checks are applied to relevant data sets and systems.

4.12.2 Data Quality Lead aka Head of Informatics/Head of Access

The Data Quality Lead is to ensure data quality reports are developed and run to meet the requirements of the system managers and employees with responsibility for data quality and completeness. They are to also ensure data extracts are available for any required audit.

4.12.3 Trust Data Warehouse Manager

The Data Warehouse Manager is to develop data load routines that check for validity and volumes of data as data is loaded into the Data Warehouse and ensure all issues are reported to the Trust Information Manager and System Managers for resolution.

4.12.4 Trust Systems Management Team

The System Management Team is to monitor and action system generated error reports and data quality issues raised directly by users as well those errors and data quality issues raised via data quality and completeness reports and audits where appropriate.

4.13 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.14 Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

4.15 Data Quality Steering Group

The Data Quality Steering Group is responsible for monitoring and working to resolve data quality issues that are identified through the identified methods within this policy. The Data Quality Steering

Group is also responsible for raising any issues to the Information Governance Steering Group and updating them on the Trusts data quality position

5 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified?**
Reviewing accuracy of data	Information Reports from Systems	Data Quality Lead/Team	Monthly	Data Quality Steering Group	The Data Quality Steering Group would develop an action plan for approval by the IG Steering Group. This would be monitored at the monthly DQ & IGSG meetings and closed once recommendations were implemented
Compliance with Data Quality Standards	Reports from Data Quality Lead	Data Quality Steering Group	Monthly	Data Quality Steering Group	
Governance of Compliance with Data Quality Standards	Reports from Data Quality Lead	Information Governance Steering Group	Quarterly	Information Governance Steering Group	
Programme of external audits (including clinical coding) – reports to be reviewed and improvement plans drawn up in accordance with IG Toolkit guidance.	Audit Report & subsequent action plans	Data Quality Steering Group / Information Governance Steering Group	Annually, as audits are completed	Information Governance Steering Group	

6 Review Date, Arrangements and Other Document Details

6.2 Review Date

This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

6.3 Regulatory Position

Data quality and completeness is audited by several external agencies including:

- CQC regulates the Trusts activity and its right to provide services.
- NHS Improvement.
- The Data Protection Act 1998 (Ref 4) requires that information held on computer systems is accurate and up to date.
- The Audit Commission carries out regular audits of data quality within its Data Assurance Framework.
- Department of Health.
- Clinical Negligence Scheme for Trusts.
- Information Governance Self-Assessment.
- Trust Data Quality Account.
- CCGs and other Commissioners.
- Nursing and Medical Professional bodies.

6.4 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	IG Toolkit	https://www.igt.hscic.gov.uk
2	Data Protection Policy	T:\Trust-wide Documents.
3	Improving Performance Policy	T:\Trust-wide Documents.
4	Data Protection Act 1998	www.legislation.gov.uk
5	Admission, Transfer and Discharge Policy	T:\Trust-wide Documents.

6.5 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Information Governance Manager	17/03/2017
Planned Care Divisional Analyst	17/03/2017
Health Records Manager	17/03/2017
Systems Management Specialist	23/03/2017
Data Warehouse Manager	16/03/2017

Appendix A – Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

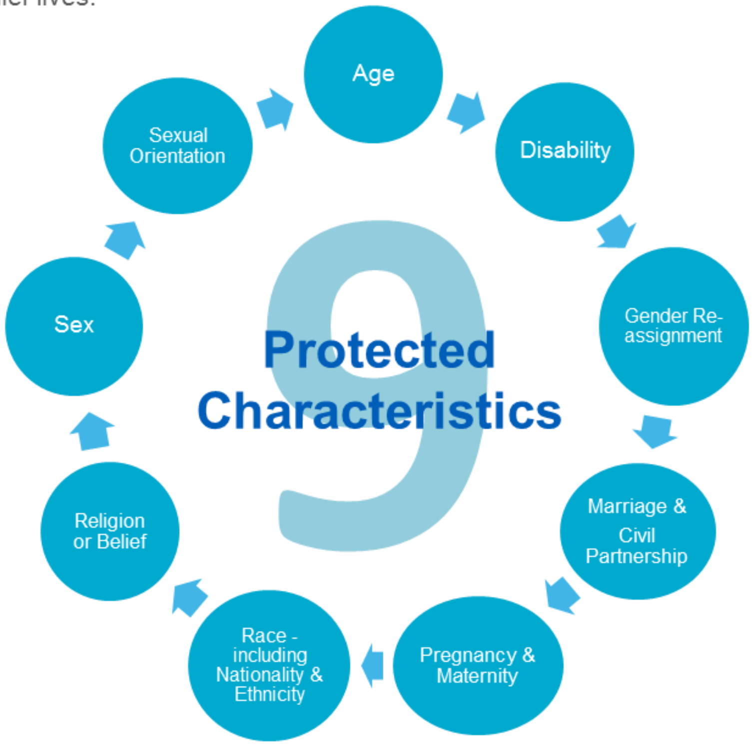
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



9 Protected Characteristics

- Age
- Disability
- Gender Re-assignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race - including Nationality & Ethnicity
- Religion or Belief
- Sex
- Sexual Orientation

Appendix B – Quality Impact Assessment Tool

Purpose - To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community.		
Process -The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.		
Monitoring the Level of Risk - The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. High Risks must be reported to the relevant Executive Lead.		
Impact Assessment Please explain or describe as applicable.		
1.	Consider the impact that your document will have on our ability to deliver high quality care.	With accurate & timely patient care is enhanced by being able to access up to date information about the patient
2.	The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care).	The impact will be positive by ensure data is accurate and high quality
3.	Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall.	N/A
4.	Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is.	N/A
Impact on Clinical Effectiveness & Patient Safety		
5.	Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm.	There should be very little impact on Clinical effectiveness and Patient Safety, there will however be learning and education towards staff and at first may increase time of records management
Impact on Patient & Carer Experience		
6.	Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment.	The patient experience will improve as with accurate data and information available in a timely way will mean the patients should be dealt with faster and have the correct information about them
Impact on Inequalities		
7.	Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language).	There will be no impact on certain groups of patients from this policy