**Trust Policy**

Worcestershire Acute Hospitals NHS Trust

# Data Quality Policy

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|---|---|
| **Department / Service:** | Digital Information Team |
| **Originator:** | Nicola O'Brien |
| **Accountable Director:** | Chief Digital and Information Officer |
| **Approved by:** | Information Governance Steering Group |
| **Date of Approval:** | 1st June 2024 |
| **Review Date:**<br>**This is the most current document and should be used until a revised version is in place** | 1st June 2027 |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | All |
| **Target staff categories** | All |

**Policy Overview:**

The Trust is aware of the necessity to ensure high levels of Data Quality exist in all forms of personal confidential data (PCD) it records, and information it produces, to comply with its legislative obligations, to facilitate the provision of the highest standards of patient care and ensure corporate records are accurate.

Pursuant with the aim of achieving a culture of unconscious competence within its workforce in relation to Data Quality, this policy outlines the roles and responsibilities of all staff.

The Trust will aim to achieve and maintain the highest standards contained within the Data Security and Protection Toolkit

**Key amendments to this Document:**

| Date | Amendment | By: |
|---|---|---|
| Jan 2015 | Includes latest guidance and reflects organisational changes and the audit cycle. | IG Manager |
| Feb 2017 | Document extended for 6 months while recruiting to post of Data Quality Manager | IG Manager |
| Aug 2017 | Documented extended for 6 months as per TMC paper | TMC |
| Dec 2017 | Document extended for 3 months as per TLG recommendation | TLG |
| Jan 2018 | Document reviewed and revised to reflect the latest Trust policies and NHS Standards. | Information Manager |
| January 2020 | Document extended for 3 months whilst undergoing approval process | Information Manager |
| 14th April 2020 | Document extended for 6 months during COVID period | |
| 6th Jan 2021 | Document review date extended by 12 months in line with amendment to Key Document Policy | Data Quality Manager |

| | | |
|---|---|---|
| Jun 2022 | Document review and revised to reflect the latest Trust Policies and NHS standards following the COVID19 pandemic | Data Quality Manager |
| Feb 2023 | Amended policy approved at TME | TME |
| May 2024 | Document review and revised to ensure alignment with the Foundation Group Data Quality Framework | Deputy Chief Information and Performance Officer |

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## 1. Introduction

The Trust recognises the necessity for the recording of accurate, relevant, timely, reliable, valid and complete patient information to support;

- The provision of high quality and safe patient care
- The delivery of its core business objectives
- The monitoring of activity and performance for internal and external management purposes.

It is the responsibility of ALL staff, clinical and non-clinical, to ensure that all information which is recorded, both in paper format and on electronic systems, conforms to the highest levels of data quality.

In order to achieve this staff must ensure that data conforms to both nationally and locally defined standards, by following the guidelines and procedures provided for data collection and reporting.

The requirement for high level data quality is outlined in the following legislative and national guidance (the list is not exhaustive);

- The Data Protection Act 2018, in particular principle 4 which states "Personal data shall be accurate and, where necessary, kept up to date.
- The Health and Social Care Act 2012 (section 266) states that our statutory data quality role is to assess the extent to which the data it collects meets defined national standards and to publish the results of the assessments.
- Section 92 of the Care Act 2014 which creates an offence of supplying, publishing or otherwise making available information, which is false or misleading in a material respect.
- CQC Regulations;
    - Regulation 12: Safe Care and Treatment, specifically the component 12(2)(c) which states that the Trust must be "ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;"
    - Regulation 17(2)(a) which states "information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance…"
    - Regulation 17: Good Governance, specifically the component 17(2)(c), which states that the Trust must "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;"
    - Regulation 17: Good Governance, specifically the component 17(2)(d) which states the Trust must be fit for purpose and "…Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable" and; "…Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf…" and; "… be maintained securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity;"

- NHS Data Dictionary, which gives common definitions and guidance to support the sharing and comparison of information across the NHS. https://www.datadictionary.nhs.uk

- The Data Protect and Security Toolkit, which is a Department of Health mandated set of standards, including Data Quality requirements, which the Trust must evidence they are compliant with.

The Data Quality policy outlines the Trust processes to ensure compliance with these requirements.

## 2. Relevance:

Data quality is important because **people in any given domain need accurate, dependable and timely information.** Having quality data can help businesses improve decision-making abilities, reduce risk and increase efficiency.

To ensure that standards of good data quality are maintained, the following actions are performed by the Data Quality Team. Monitor and compare national and local data quality reports, ensuring any discrepancies are resolved. Cleanse patient records by identifying data quality issues in demographics by batch tracing the data and rectifying any variances identified. Identify the staff that are creating erroneous entries on the system and work with them, and the training team, to eliminate the potential of these issues reoccurring. Assist in identifying duplicate patient records and bringing to the attention of the Medical Records department to ensure clinical notes are combined

## 3. Scope of this document

The scope of this Policy is Trust Wide, regarding both unstructured and structured data, with both clinical and non-clinical staff responsible for the accuracy and completeness of any personal confidential data (PCD) they record.

The principles outlined in this policy are applicable to ALL data recorded by, and information produced by the Trust, in either paper or electronic format. All clinical and non clinical systems are within scope, some are included below for reference, however this is not an exhaustive list.

- Altera PAS
- Altera Sunrise
- CRIS
- ICE
- ESR
- WinPath
- Ascribe
- Bluespier
- DATIX
- Patient First
- Bereavement Database
- Badgerne
- Badgernet
- Medicode

Each department is responsible for producing their own procedures relating to how they interact with data capture; each data quality dimension (six) should be covered. All staff must also be up to date with their mandatory Data Security and Protection training which includes how to maintain and protect data, and access to clinical and non clinical systems will be accompanied with training.

**Supporting documents:**
The Data Quality Policy is to be read in conjunction with;

- The Corporate Records Management Policy and Procedure (WAHT-CG-127)
- The Clinical Coding and Auditing Policy and Process (WAHT-CG-774)
- The Information Governance Policy (WAHT-CG-579)
- The Data Protection Policy (WAHT-IG-004)
- The Clinical Record keeping and Records Management Policy (WAHT-CRK-09)

## 4. Definitions

- **Data** – that which is input to a system, or extracted from a system in an unanalysed format.
- **Information** – that which is produced by extracting and analysing data from a system(s)
- **Data Quality** – the extent to which the data conforms to the dimensions of data quality.
- **Dimension** – a facet of data that can be measured or assessed against defined standards in order to determine the quality of data. For the purpose of this policy the dimensions are Accurate, Valid, Reliable, Timely, Relevant and Complete.

Putting patients First is at the core of Trust philosophy. A 'golden thread' that runs through the strategic objectives is high quality data – A patient's medical record is equally as important as how the patient has been clinically treated – poor data quality can lead to a huge patient safety risk and the policy below outlines how to achieve good data quality.

## 5. Data Quality Principles

- **Accurate (dimension)** – the level to which the data corresponds to real world values at the point in time it is being used. We have accuracy when data reflects reality. For example, this can refer to correct names, addresses or represent factual and up to date data. Real-world information can change over time. This makes accuracy quite challenging to monitor. it also leads to correct reporting and confident decision-making
- **Valid (dimension)** – the level to which the data conforms to its associated rules and definitions. Validity is defined as the extent to which the data conforms to the expected format, type, and range. For example, an email address must have an '@' symbol; postcodes are valid if they appear in the Royal Mail postcode list; month should be between one and twelve.

- **Reliable (dimension)** – the level to which the data is consistent across time and systems. Consistency is achieved when data values do not conflict with other values within a record or across different data sets. For example, the first characters in a postcode should correspond to the locality of the address. Similarly, date of birth for the same person in two different data sets should be the same.

- **Timely (dimension)** – the level to which the data is available when it is expected and needed. Timeliness indicates whether the data is available when expected and needed. Timeliness means different things for different uses. In a hospital setting, timeliness is critical in ensuring the most up to date data in a bed allocation system. However, it may be acceptable to use previous quarterly figures from healthcare records to forecast care needs and plan health and social care services.

Data quality may diminish over time. For example, someone might provide the correct address or job title when the data is captured, but if the same individual changes their address or job these data items will become outdated.

Timeliness is important as it adds value to information that is particularly time sensitive. Timely data during the pandemic made health care provisions more responsive and saved lives.

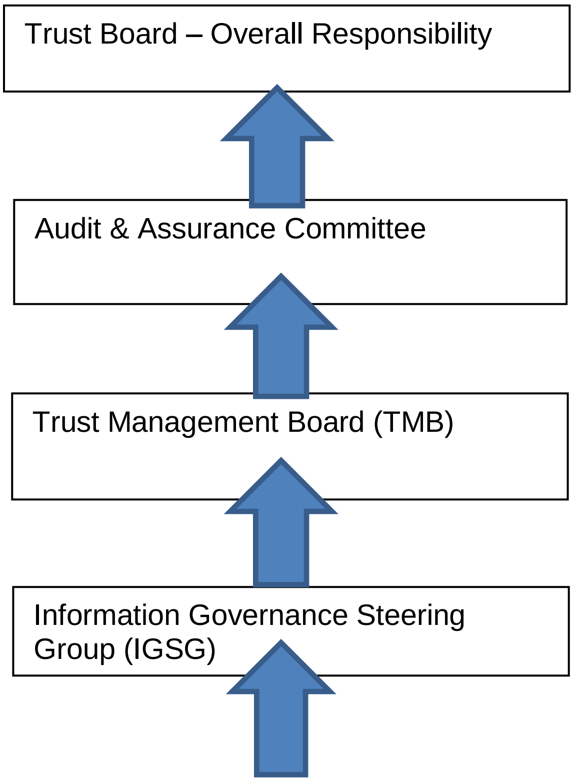
- **Relevant (dimension)** – the level to which the data answers the purpose for which it is collected. Data should be defined, selected, collected, recorded and analysed with the intended use and audience in mind.
- **Complete (dimension)** – the level to which a data item or data set is complete. Data is considered complete when all the data required for a particular use is present and available to be used. It's not about ensuring 100% of your data fields are complete. It's about determining what data is critical and what is optional.

## 6. Roles and Responsibilities

- **Everyone – Any person who is capturing structured or unstructured data is <u>responsible</u> for ensuring that the data recorded meets a high standard for all six of the data quality dimensions.**

However, there are some key individuals who provide the tools to all to ensure that data quality is of a high standard and compliant with national and local guidance.

**Reporting Hierarchy**:



Data Quality Steering Group (DQSG)

- **The Data Quality Steering Group (DQSG) –** Monitors critical data and investigates any concerns related to Data Quality. It is authorised to seek any information it requires from any employees, and all employees are directed to co-operate with any reasonable request made by the Data Quality Steering Group. Reports to the IGSG. Activities include;

    - Develop and monitor specialty, divisional and trust-wide actions to address any significant data quality concerns.
    - Oversight of the value for money audit and any other audit internal/external relevant to Data Quality.
    - Oversee the progress of improvement in relation to the National Data Quality Standards for Elective Recovery.
    - To obtain assurance that the Trust is progressing and compliant with Information Standards Notices (ISNs).
    - To review completed Data Quality Kitemarks and ready for approval at Trust Management Board.
    - To ensure that policy and procedure documents surrounding data collection, processing and validation are in place, up-to-date and conform to national standards.

- **The Caldicott Guardian -** Ensures that Patient Identifiable Information (PII) is handled, accessed and distributed according to National and Trust protocols and legislation.

- **The Clinical Lead for Data Quality –** Leads on ensuring clinical engagement with the data quality agenda.

- **The Deputy Chief Information and Performance Officer -** Responsible for ensuring the Digital Information Department, which includes the Data Quality Team, are monitoring and managing the data quality agenda according to national and local policies and procedures.

- **The Information Department - Data Quality Team**

    - ➢ **Data Quality Manager -** Leads in communicating the Data Quality Agenda trustwide. This includes communicating any national data quality policy changes, new Information Standard Notices (ISN), providing guidance on data quality issues, and leading on data quality investigations into identified issues. Reports the results of any investigations to the DQSG

    - ➢ The Data Quality Manager is supported by the Data Quality team of 2 WTE.

- **Information Asset Owners -** Staff who have responsibility for managing local electronic systems for record keeping. They must ensure that all systems for which they are responsible comply with the NHS Data Dictionary and Information Governance protocols. Due to the lack of interoperability between some legacy systems, procedures should also be in place for updating demographic data from local systems to Allscripts PAS.

## 7. Key Systems: The Patient Administration System (Altera PAS) and the electronic patient record (Altera EPR)

PAS/EPR is the master system(s) for the trust and covers a wide range of clinical and administrative processes which includes: all clinical treatment and monitoring; the patient master index; all aspects of inpatient and outpatient activity and waiting list management. Data Quality errors on PAS/EPR can result in patient harm, distress, or sub-standard experience.

Data is extracted from PAS/EPR and submitted to SUS (Secondary Uses Service) to facilitate payment to the Trust. Failure to maintain high quality data could result in underfunding for the Trust and harm the sustainability of future services.

Therefore, it is essential that all patient related activity is recorded in an accurate and timely manner and according to national data standards.

**The Patient Administration System/Electronic Patient Record must be regarded as the principal source of patient information and where departmental systems are in place, care must be taken to ensure that any updates in demographic data recorded on the departmental system are also entered on the Patient Administration System.**

## 8. Static demographic details including NHS Number

The NHS Number is the preferred identifier when transferring data across NHS organisations. All clinical documentation, both paper and electronic, must include the NHS number when it is known. It is mandatory for inclusion in all commissioning dataset transmissions and when present other patient identifiers are removed. For clinical documentation it is used as a check on patient identification.

Every effort will be made via use of the NHS Summary Care Record to improve and maintain the completeness, accuracy and verification of this identifier both by individual enquiries and by a programme of batch tracing.

A static data item in regard to patient demographic detail is defined as either:
1. the patient’s Date of Birth or
2. the Patient’s NHS Number (This will only change on adoption or sex change operation)

These are details that will never change and so governance is required around these areas to ensure if a change is needed it is checked against the SPINE and signed off by a supervisor and shared with the Data Quality Manager for implementation.

Insufficient checks can put the patient at risk as it may lead to records being merged for different patients believing they are in fact the same patient.

A patient’s NHS Number and Date of Birth are the only data elements that are deemed static so should always be used in the first instance when searching for a patient on any Trust System

### Who is authorised to make the change to the patient record

**Non static** demographic details such as updates to names and addresses (not an exhaustive List) all staff are allowed to update the system

**Static data** details may only be changed by the Data Quality Team or nominated Health Records team member following an investigation of Trust systems and the SPINE. If illegitimate changes are found they will be escalated to the Health Records Manager/Team for Investigation. On escalation the Health Records Team will investigate and will involve the GP and Integrated Care System (ICS) where appropriate.

The Health Records Team will provide feedback to the requestor.

Appendix 1 Searching for a patient using Static Demographic details contains a diagram of the above process

## EXTERNAL

### 9. Data Protection and Security Toolkit (DSPT)

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

All mandatory training is completed via your personal ESR login under compliances, this can be done via smartcard or your ESR login any issue with this please contact the ESR team at wah-tr.ESRSelfServiceHelpdesk@nhs.net

### National Data Opt Out

In May 2018, the National Data Opt Out (NDOO) was introduced giving patients the option of opting out of their personal data being used for research and planning.

To ensure we are compliant with patients wishes the Data Quality team will run a process to check for any NHS Number that has opted out so we can remove their information from any research and planning audits. Every NHS number to be used has to be checked for each audit as patients can opt in or out at any time.

### 10. Value for Money Audit

Under the National Audit Office (NAO) Code of Audit practice we are required to consider whether the Trust has in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors report in more detail on the Trust's overall arrangements, as well as key recommendations an any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under specified criteria – Financial Sustainability, Governance and Improving economy, efficiency and effectiveness in its use of resources.
Data Quality is a 'golden thread' through this audit.

## 11. NHSE/I –National Waiting Lists

The LUNA National Data Quality solution has been developed, at the request of NHS England & NHS Improvement, to provide an up to date national view of data quality from all providers across England.

Since COVID the backlog of waiting lists is significant so mandated DQ requirements has to be considered to ensure the best quality information is held providing a true reflection on actual Waiting List numbers. There is a sample of Data Quality rules shown in Appendix 2.

The National Team will instruct Trusts of the most up to date Data Quality targets, for the latest targets please contact the Data Quality Team.

## 12. SUS (Secondary Uses Service)

Data collected within the Trust is submitted to SUS. Quality checks on this data are performed prior to the submission by the Digital Information team. Data Quality dashboards returned from SUS show both the Trusts current standards and national standards.

### Data Quality Maturity Index (DQMI)

The Data Quality Maturity Index (DQMI) is a monthly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality.
The DQMI scores are reported monthly to the Data Quality Steering Group.

Link to DQMI is Data quality - NHS Digital

### Artificial Intelligence & Machine Learning

As part of the Digital Care Record (DCR) Strategy, the Trust has begun to engage with third party suppliers specifically in relation to machine learning and artificial intelligence. Any projects being piloted in this area should be discussed with the Digital ICT department and authorised via its Work Review Group. The Digital ICT team will then use its project management methodology to retain an overview of the project and ensure that Information Governance, Cyber Security, and other due diligence is completed. The team will also liaise with any relevant clinical safety representatives to ensure that the best interests of the patients are also considered.

## 13. Data Sharing

Any Trust data that is to be shared externally to the organisation should be done so in accordance with the Trust Information Governance Policy. Any requests to access data directly from any Trust clinical system or in-built application will need to be discussed with the Digital Division (specifically the Digital ICT Department, Digital Information Department and the Information Governance team).

The Integrated Care System developments should be discussed in the Digital, Data and Technology Group where authorisation is required, however overall responsibility to allow access to data and information within the Trust remains at the discretion of the Trust Management Board, following advice and guidance from the Digital Division.

## 14. Training

Training for all trust systems is arranged via the Digital ICT Training Department and all training sessions will ensure staff are aware of the importance of good quality and the timely collection of data.

It is the responsibility of all staff to attend training on any system to which they record data.

It is the responsibility of all managers to ensure that their staff have attended system training.

Link to IT Training: Training Resources (worcsacute.nhs.uk)
Email for RTT Training: wah-tr.ValidationQueries@nhs.net

## 15.Getting it Right First Time – Reference Guide -GIRFT

Getting it Right First time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting a data driven evidence to support change. The GIRFT national programme is designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations and sharing best practice between trusts, GIRFT identifies changes that will improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures and cost savings.

The importance of having good data quality will help inform the GIRFT programme, enabling the focus to be on areas of opportunity rather than areas where performance is being negatively impacted by poor data quality.

For further Information regarding GIRFT please email strategy & planning on: wah-tr.cpmo@nhs.net

A quick reference guide highlighting some key data quality fields to be aware of aimed at helping to avoid the creation of unwanted variation is available in Appendix 3.

## 16. Policy Review

This policy will be reviewed every year by the Data Quality Manager, unless changes to national requirements are released.

## 17. Monitoring and Compliance

The table below should help to detail the ‘Who, What, Where and How’ for the monitoring of this policy.

| Key control: | Checks to be carried out to confirm compliance with the policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|
| **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| Payment by Results Audits: This is a national audit covering inpatients, out patients and coding on a rolling 3 year program. | The Trust will organise an audit of its coded inpatient data.<br>These audits validate the quality of the data recorded on the PAS and the source documentation written in the case notes. | Yearly | External Auditor | Information Governance Steering Group<br>Audit Committee | Yearly |
| **SUS (Secondary Uses Service):** Data collected within the Trust is submitted to SUS (monthly/weekly). | Quality checks on this data are performed prior to the submission by the information team. | Monthly/weekly | Information Team | Data Quality Group review the SUS Data Quality dashboards | 10 times a year |
| The information department provide many reports throughout the Trust. These may be for all or some of the directorates, individual departments or ad hoc reports when requested. | Directorate validation of data quality reports such as:<br>• 18 week activity<br>• waiting list validation lists<br>• Activity outcomes validation lists<br>• A&E waiting times validation<br>• Patient Master Index DQ<br>• DQ indicators report | Monthly/weekly | Directorate staff/Directorate validation staff | Reported directly back to directorate managers | Validation is an on-going process |
| Missing demographic data from PAS | Updating data, such as:<br>• NHS Number<br>• PMI Details | Weekly | Data Quality Clerks | Reported through the Data Quality Group | Validation is an on-going process |
| **Data Quality Policy - Workforce Information** | | | | | |
| ESR Annual Assessment | The Trust is assessed by Regional ESR Functional Lead each year following a national template. This audit validates the use of ESR functionality and user roles | Annually | External ESR Functional Lead | Director of People and Culture/People and Culture Committee | Annually |
| Validation Checks between WREN and ESR | Manual validation between the data that is pulled from ESR against that published on the SitRep report on WREN | 3 times a year | Workforce Information Team | Informatics/Director of People and Culture | 3 times a year |
| Review of Data Quality BI Report from ESR | Review of issues/conflicts picked up from the standard national BI report on Data Quality | 4 times a year | Workforce Information Team | Will go to Data Quality Steering Group | 4 times a year |
| Validation of interface between ESR and HealthRoster | Fails report run each month/week after each payroll upload | weekly for weekly payroll/monthly for monthly payroll | E-rostering Team in liaison with Workforce Team | HR Seniors - exception reporting only | By exception |
| Various External and Internal Audits of Payroll | Checks against Starter, Change and Termination forms and User Access | Annually | Coventry and Warwickshire Audit and other appointed external auditors | Audit Committee | Annually |
| User Responsibility Profile Checks | URP report run monthly to check access is correct | Monthly | Workforce Information Team/Learning and Development Team | HR Seniors - exception reporting only | By exception |

## 19. Equality requirements

The equality impact assessment tool has been completed and shows no equality risks.(Supporting Document 1)

## 20. Financial Risk Assessment

The financial risk assessment has been completed and shows no financial risks. (Supporting +Document 2)

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## Supporting Document 1 – Equality Impact Assessment form

### Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
### Please read EIA guidelines when completing this form

**Section 1 - Name of Organisation** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Herefordshire & Worcestershire STP | | Herefordshire Council | | Herefordshire CCG | |
| Worcestershire Acute Hospitals NHS Trust | ✓ | Worcestershire County Council | | Worcestershire CCGs | |
| Worcestershire Health and Care NHS Trust | | Wye Valley NHS Trust | | Other (please state) | |

| | |
|---|---|
| **Name of Lead for Activity** | **Jayne Dashey** |

| | | | |
|---|---|---|---|
| **Details of individuals completing this assessment** | **Name** | **Job title** | **e-mail contact** |
| | **Jayne Dashey** | **Interim Data Quality Manager** | **jayne.dashey@nhs.net** |
| | | | |
| | | | |
| **Date assessment completed** | **25/06/2024** | | |

**Section 2**

| | | | | |
|---|---|---|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | **Title: Data Quality Policy** | | | |
| What is the aim, purpose and/or intended outcomes of this Activity? | Capturing improved Quality of Demographics | | | |
| Who will be affected by the development & implementation of this activity? | ✓<br>✓<br>✓<br>✓ | Service User<br>Patient<br>Carers<br>Visitors | ✓<br>✓<br>☐<br>☐ | Staff<br>Communities<br>Other ______________________ |
| Is this: | ✓ Review of an existing activity<br>☐ New activity | | | |

| | |
|---|---|
| | ☐ Planning to withdraw or reduce a service, activity or presence? |
| What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc. | Please complete |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | Please complete |
| Summary of relevant findings | Please complete |

## Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

| **Equality Group** | **Potential <u>positive</u> impact** | **Potential <u>neutral</u> impact** | **Potential <u>negative</u> impact** | **Please explain your reasons for any potential positive, neutral or negative impact identified** |
|---|---|---|---|---|
| **Age** | ✓ | | | |
| **Disability** | ✓ | | | |
| **Gender Reassignment** | ✓ | | | |
| **Marriage & Civil Partnerships** | ✓ | | | |
| **Pregnancy & Maternity** | ✓ | | | |
| **Race including Traveling Communities** | ✓ | | | |
| **Religion & Belief** | ✓ | | | |
| **Sex** | ✓ | | | |
| **Sexual Orientation** | ✓ | | | |
| **Other Vulnerable and Disadvantaged Groups** (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.) | ✓ | | | |

| Equality Group | Potential **positive** impact | Potential **neutral** impact | Potential **negative** impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Health Inequalities** (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies) | ✓ | | | |

## Section 4

| | | | | |
|---|---|---|---|---|
| **What actions will you take to mitigate any potential negative impacts?** | **Risk identified** | **Actions required to reduce / eliminate negative impact** | **Who will lead on the action?** | **Timeframe** |
| | | . | | |
| | | | | |
| | | | | |
| **How will you monitor these actions?** | | | | |
| **When will you review this EIA?** (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation) | | | | |

**Section 5** - Please read and agree to the following Equality Statement

## 1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

| | |
|---|---|
| **Signature of person completing EIA** | |
| **Date signed** | |
| **Comments:** | |

| | |
|---|---|
| **Signature of person the Leader Person for this activity** | |
| **Date signed** | |
| **Comments:** | |

NHS Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

NHS Wye Valley NHS Trust

NHS Worcestershire Health and Care NHS Trust

2gether NHS Foundation Trust NHS

Taurus Healthcare

worcestershire county council

Herefordshire Council

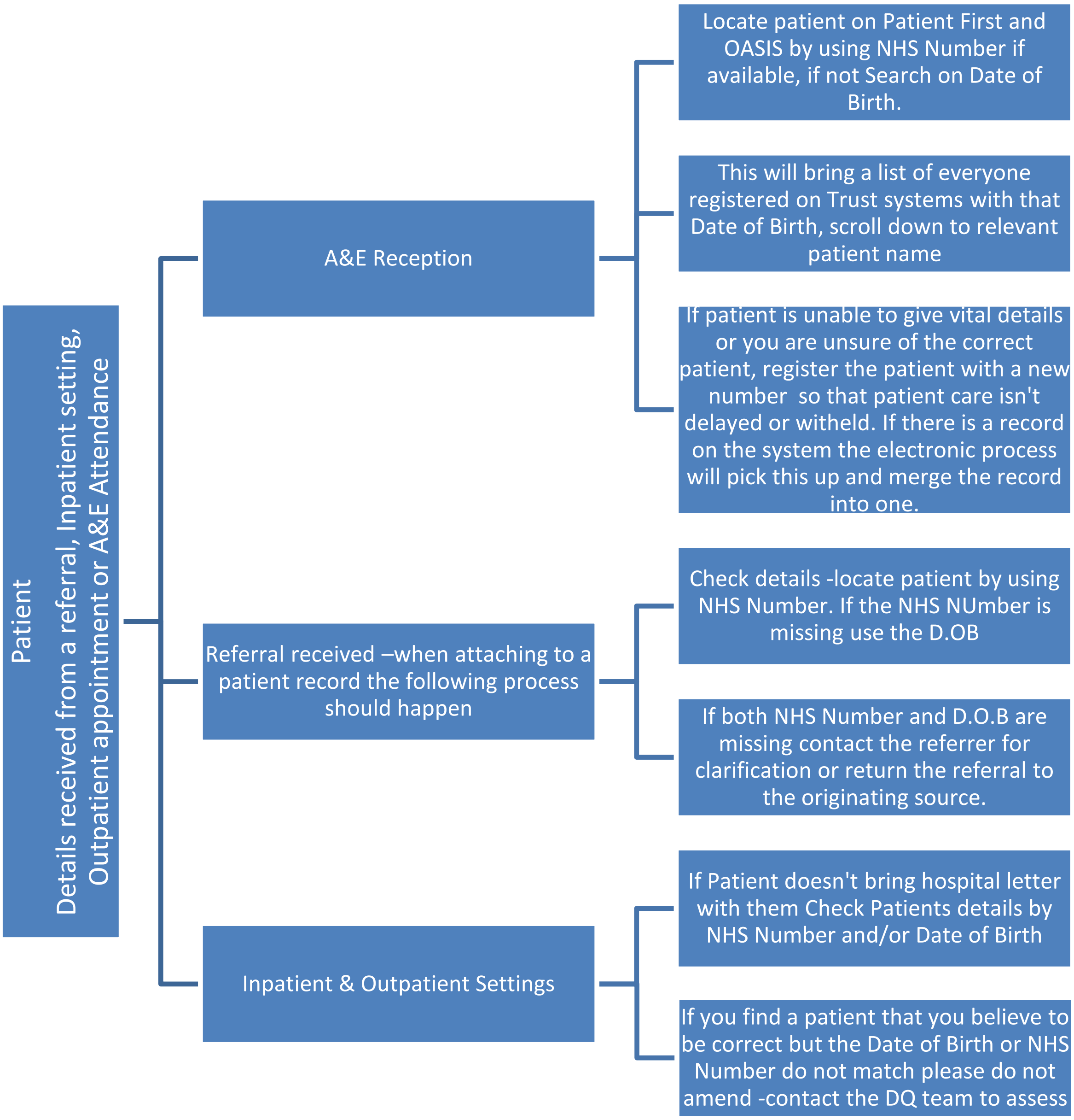
## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | **Title of document:** | **Yes/No** |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | None |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

## Appendix 1- Searching for a patient using Static Demographic details:



Patient

Details received from a referral, Inpatient setting, Outpatient appointment or A&E Attendance

A&E Reception

Locate patient on Patient First and OASIS by using NHS Number if available, if not Search on Date of Birth.

This will bring a list of everyone registered on Trust systems with that Date of Birth, scroll down to relevant patient name

If patient is unable to give vital details or you are unsure of the correct patient, register the patient with a new number so that patient care isn't delayed or witheld. If there is a record on the system the electronic process will pick this up and merge the record into one.

Referral received –when attaching to a patient record the following process should happen

Check details -locate patient by using NHS Number. If the NHS NUmber is missing use the D.OB

If both NHS Number and D.O.B are missing contact the referrer for clarification or return the referral to the originating source.

Inpatient & Outpatient Settings

If Patient doesn't bring hospital letter with them Check Patients details by NHS Number and/or Date of Birth

If you find a patient that you believe to be correct but the Date of Birth or NHS Number do not match please do not amend -contact the DQ team to assess

## Appendix 2

## LUNA Data Quality rules:

Outcome of Discharged or Invalid
Potential Duplicate different clock start
Current RTT Status is 99
Admission method planned or invalid
Current RTT status is 90,91
Over 40 weeks waited and not validated
Source of referral ED
Current RTT Status of 30-36
Potential Duplicate same clock start
Current RTT status is 21
TF is no-RTT missing or invalid
Current RTT Status is 98

This is the current rules at May 2024 but will be subject to change as national guidance is amended.

## Appendix 3 – "Right First Time" Reference Guide

| | |
|---|---|
| 1 | ALWAYS **ASK** THE PATIENT to state their:<br>a. Address<br>b. DoB<br>c. Postcode<br>d. GP<br>e. Ethnic origin (if not already on the system)<br>f. NHS number (if not already on the system) |
| 2 | Use the 'INSERT' facility to change a patient's address. **DO NOT OVERTYPE EXISTING RECORD.** |
| 3 | Overseas patients - Record overseas address in permanent field. |
| 4 | Carry out a thorough check before you register a patient to ensure the patient isn't on the system. Use the Summary Care Record (SCR) to assist you by using the NHS number in the search. |
| 5 | Record new appointments and follow up correctly, using correct clinic type. |
| 6 | At the end of each clinic check all patients are on the system with the correct details and have been 'outcomed'. |
| 7 | Ensure any 'unspecified WL entries' are updated with full details. |
| 8 | Always check you have selected the correct TCI to ensure the correct episode details are recorded for the patient. |
| 9 | Check all admission, ward and consultant transfer and discharge details especially recording dates correctly. |
| 10 | Only use the transfer transaction when patients move between the 3 acute sites (WRH, ALX & KTC), otherwise the patient should be discharged. |
| 11 | Use the ward leave facility to record patients on home leave. |
| 12 | Maternity – Mothers estimated date of delivery MUST be recorded on PAS. Mother and baby episodes need to be linked correctly. |
| 13 | Clinical Coding - If you add a late admission to the system please notify the coding staff on your site. |
| 14 | It is essential to ensure notes are retained on the wards for the coders to collect or sent to coding, (whichever is the process for your site). |
| 15 | New / Change of Service form – Need to be used to record all new or changes to any activity on PAS and the Information Department **must** be copied in regarding all changes. These forms are now available electronically, please refer to the intranet. |