Legal and National Guidance

**Data Protection Act 2018**
Came into force on 23rd May 2018 covers all types of manual and electronic information which can identify a living individual and the Trust has a legal duty to ensure that the data it collects is accurate and up to date.

**Health and Social Care Act 2012**
Came into force on 1st April 2013, states that the Secretary of State for Health and NHS England are is responsible for preparing, or adopting, and publishing the information standards against which NHS Digital assesses the quality of the data it receives.

NHS Digital statutory data quality role is to assess the extent to which the data it collects meets applicable published standards and to publish the results of the assessments. In addition, NHS Digital may give advice or guidance on data quality relating to the collection, analysis, publication or other dissemination of data and information.

NHS Digital data quality assurance role is being developed to include delivery of its statutory obligations under the Act and is closely aligned with the ‘Assessment’ function of the proposed national data quality framework.

NHS Digital develops its own data standards based on its extensive knowledge and experience of the data it receives and uses them, in conjunction with national data standards, to assess data quality. NHS Digital also gives advice and guidance on data quality to facilitate improvement.

The Trust has to collect and submit to NHS Digital a number of **national data sets** including:
- Mental Health & Learning Disabilities Minimum Data Set
- HES Outpatient Data Set
- HES Inpatient Data Set
- IAPT Data Set
- CSDS – Community Service Data Set

NHS Digital are responsible for the **NHS Data Model and Dictionary** which provides a reference point for approved Information Standards and Collections (including Extractions) (ISCEs) to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS. The NHS Data Model and Dictionary is maintained and published by the NHS Data Model and Dictionary Service. Changes are published as Information Standards and Collections (including Extractions) Notices (ISCE) and Data Dictionary Change Notices (DDCN) and are held on the NHS Digital website.
The “Quality of Nationally Submitted Health and Social Care Data Annual Report 2013” (published on 24th September 2013 by the NHS Digital) highlighted the importance of high quality data in the provision of health services and referenced the following two national reports which highlighted data quality issues:

- The report by Mr Robert Francis QC on the Mid Staffordshire NHS Foundation Trust Public Inquiry and the report issued by Dame Fiona Caldicott following her review of information governance both highlight issues with data quality in health and social care and the impact these issues have on direct and indirect uses of data.
- Both reports recommend how these issues could be resolved.
- Francis states that the accuracy of records is vital if safe care is to be delivered to patients and that it is clear from the Inquiry relating to the coding issues arising in the Trust that there is potential for providers’ data from which healthcare statistics are produced to be inaccurate to an extent that undermines the reliability of subsequent analysis. Francis subsequently recommends that the only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system and that this is important work which must be continued and where possible improved. This auditing is undertaken routinely across the Trust and the mechanisms are detailed in the accompanying Procedure.
- Caldicott states that poor data quality can directly affect the quality of direct patient care and gives examples of this in her report including clinicians making decisions about treatment on the basis of incorrect information. Poor data quality can be caused by poor practice, such as professionals recording data inaccurately, or can result from poor standards or procedures, e.g. having systems that do not allow an accurate or suitably detailed expression of a patient’s or client’s condition. Caldicott recommends therefore that regulatory, professional and educational bodies should ensure that sound record keeping and the importance of data quality are part of continuous professional development and are assessed as part of any professional revalidation process. This has been addressed by the Trust and is detailed in the accompanying Procedure.

Department of Health’s Information Strategy “The Power of Information: putting all of us in control of the health and care information we need” (May 2012)

The strategy sets out a ten year framework for transforming information in health and care. It aims to harness information and new technologies to achieve higher quality care and improve outcomes for patients and service users. Underpinned by the Health and Social Care Act 2012, it covers public health, healthcare and social care in adult and children’s services in England.

The Strategy’s main ambitions are:
- Information used to drive integrated care across the entire health and social care sector, both within and between organisations;
- Information regarded as a health and care service in its own right for us all – with appropriate support in using information available for those who need it, so that information benefits everyone and helps reduce inequalities;
- A change in culture and mindset, in which our health and care professionals, organisations and systems recognise that information in our own care records is fundamentally about us – so that it becomes normal for us to access our own records easily;
• Information recorded once, at our first contact with professional staff, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure;
• Our electronic care records progressively become the source for core information used to improve our care, improve services and to inform research, etc. – reducing bureaucratic data collections and enabling us to measure quality;
• A culture of transparency, where access to high-quality, evidence-based information about services and the quality of care held by Government and health and care services is openly and easily available to us all;
• An information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve our care;
• The widespread use of modern technology to make health and care services more convenient, accessible and efficient;
• An information system built on innovative and integrated solutions and local decision-making, within a framework of national standards that ensure information can move freely, safely, and securely around the system.

Chapter 3 of the Strategy is the most relevant chapter for data quality and focuses on how health and care professionals can use connected information and new technology to join up and improve services, to inform the decisions they make and to help deliver safer, more integrated care. This chapter also outlines a future in which electronic care records become a source of core professional information. Issues particularly relevant to data quality include:
• Health and care professionals will be able to access relevant records online – simply, securely and all in one place (eg. via ‘clinical portals’ or other solutions).
• Information standards will be set nationally for the whole health and care system, so that different parts can connect and communicate with each other and to improve the consistency and quality of information.
• The NHS number will be used consistently.
• The Department of Health and NHS Commissioning Board will pilot new ways to incentivise the use of integrated barcode medication administration systems in care homes by 2014, with the results informing wider implementation planning.
• Professionals will lead better, more standardised and useful recording of information in our records, wherever possible capturing data at the point of care.
• Data from our records will be combined and linked together with other data in a secure environment, then made anonymous. This data will be used to audit quality, improve services, guide commissioning, and identify trends and patterns of health.
• Over time the information from combined records will replace cumbersome national data collections.

Data Security and Protection Toolkit (DPST)
The DPST includes a number of requirements that relate to data quality to some degree and compliance with them supports improvements in the quality of data recorded. The Trust assesses itself on an annual basis against the requirements of the DPST.