

# Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)

## Data Quality Policy 2021 - 2023

### Ratification Process

Lead Author(s):	Associate Director of Business Intelligence Senior Information Manager
Reviewed / Developed by:	Cambridgeshire and Peterborough CCG Information Governance, Business Intelligence and IM&T Steering Group
Approved by:	Cambridgeshire and Peterborough CCG Information Governance, Business Intelligence and IM&T Steering Group – 22 <sup>nd</sup> April 2021
Ratified by:	Integrated Performance and Assurance Committee
Date ratified:	25 <sup>th</sup> May 2021
Version:	4.2
Review date:	May 2023 (or earlier if significant change to local or national requirements)
Valid on:	25 <sup>th</sup> May 2021

## Document Control Sheet

Development and Consultation:	Policy developed in consultation with the Information Governance (IG) Business Intelligence (BI) and IM&T Steering Group and approved by the Integrated Performance and Assurance Committee (IPAC).
Dissemination	This policy will be promoted within the Clinical Commissioning Group (CCG) and uploaded to the website
Implementation	The Chief Finance Officer is responsible for monitoring the application of the policy by ensuring that: <ul style="list-style-type: none"> <li>• The Policy is brought to the attention of all employees</li> <li>• Managers are aware of their responsibilities for ensuring that staff under their control implement the policy</li> <li>• Appropriate training and guidance is provided to relevant staff</li> <li>• Corporate business processes support the implementation of the policy</li> </ul>
Training	Training will be undertaken as part of the CCG's on-going processes.
Audit	Implementation of the Policy will be monitored on a regular basis and in conjunction with the CCG's Information Governance Toolkit requirements.
Review	This policy will be reviewed bi-annually or earlier if there are changes in procedures or legislation.
Compliance with national standards	This policy supports the CCG in its Data Security and Protection Toolkit submission and compliance.
Links with other documents	The Policy should be read in conjunction with: see Section 1 – Policy Statement
Equality and Diversity	The IG Administrator has carried out an E&D Impact Assessment and concluded the policy is compliant with the CCG's Equality and Diversity Policy. No negative impacts were found.

## Revisions

Version	Page/ Para No	Description of change	Date approved
1		Developed as a new policy for Cambridgeshire and Peterborough CCG	October 2013
2		Reviewed and ratified by CMET	July 2015
3	Whole document	Reviewed and updated prior to IG, BI, and IM&T Steering Group approval and CEC endorsement	May 2017
4	Whole document	Reviewed and updated prior to IG, BI, and IM&T Steering Group approval and IPAC endorsement. Specific reference to pseudonymisation included. IG Lead updated and amended out of date references.	May 2019
4.1	Para 1 & 3	Addition of reference to Risk Stratification	April 2020
4.2	Whole document	Reviewed and updated prior to IG, BI, and IM&T Steering Group approval and IPAC endorsement. Addition of section on Audit of Service User Data.	April 2021

## CONTENTS

	<b>Page</b>
1. POLICY STATEMENT .....	4
2. PURPOSE.....	4
3. OBJECTIVES.....	4
4. THE STRUCTURE AND SCOPE OF THE DATA QUALITY POLICY .....	5
5. GENERAL PRINCIPLES.....	6
6. PERSON IDENTIFIABLE DATA (PID) .....	6
7. RESPONSIBILITY AND ACCOUNTABILITY FOR DATA QUALITY .....	7
8. TRAINING .....	9
9. EXTERNAL SOURCES OF DATA .....	9
10. AUDIT OF SERVICE USER DATA .....	9
11. MONITORING.....	9
12. DATA QUALITY STANDARDS .....	10
13. VALIDATION METHODS.....	10
14. IMPLEMENTATION OF THE POLICY.....	11
ANNEX A – Equality Impact Assessment Form.....	12

## 1. POLICY STATEMENT

Cambridgeshire and Peterborough CCG recognise that reliable information is fundamental in supporting the CCG to achieve its goals. The CCG recognises that all the decisions, whether clinical, managerial or financial need to be based on information which is of the highest quality.

This policy should be read in conjunction with the following policies:

- CCG Records Management and Lifecycle Policy;
- CCG Code of Conduct for Employees in Respect of Confidentiality;
- CCG Information Security Staff Policy;
- CCG Safe Haven Policy;
- CCG Freedom of Information and Publication Scheme Policy;
- CCG Disciplinary Policy;
- CCG IG Forensic Readiness Policy;
- CCG Risk Stratification Policy;
- Cambridgeshire and Peterborough Multi Agency Information Sharing Framework.

## 2. PURPOSE

The purpose of this document is to set out a clear policy framework for maintaining and increasing high levels of data quality within Cambridgeshire and Peterborough CCG.

Good data quality is essential and the availability of complete, accurate, relevant, accessible and timely data is important in supporting patient care, clinical governance, management and contracts for healthcare planning and accountability. A data quality policy and regular monitoring of data standards are a requirement of the NHS Digital's Data Security and Protection Toolkit (DSPT).

## 3. OBJECTIVES

The Data Quality Policy underpins the CCG's objective to record and present data of the highest possible quality and that all users of the information can be confident about its accuracy. This is especially relevant with the increased use of Risk Stratification tools.

### What is Data Quality?

- 3.1 Data quality is the ability to supply accurate, timely and complete data, which can be translated into information, whenever and wherever this is required. Data quality is vital to effective decision making at all levels of the organisation.
- 3.2 Supplying accurate data is a complicated task for a number of reasons:
  - There are many ways for the data to be inaccurate – data entry errors and incomplete data, etc.
  - Data can be corrupted during translation depending on who is translating it, how and with what tools/processes.
  - Data must relate to the correct time period and be available when required.
  - Data must be in a form that is collatable and which can then subsequently be analysed.

- 3.3 To ensure an organisation achieves data quality, it must set out how:
- Data is collected and co-ordinated.
  - Data is transferred between systems.
  - Data is organised.
  - Data is analysed.
  - Data is interpreted.
  - Conclusions and results drawn from the data are validated.
- 3.4 The following principals are used in assessment of data quality:
- Integrity: Is the data correct and is it valid?
  - Accessibility: Can the data be readily and legally collected?
  - Comprehensiveness: Is the relevant data collected and are any data omissions (where intentional or otherwise known) documented.
  - Consistency: Are clear and accurate data definitions implemented and adhered to? Do the data definitions define what level of detail is collected?
  - Validity: Is the data up-to-date?

#### **4. THE STRUCTURE AND SCOPE OF THE DATA QUALITY POLICY**

- 4.1 This policy is intended to cover the collection, recording, validation, further processing and reporting of all types of reference information generated and used within, or reported externally by, the CCG. It describes the necessary features of systems to manage such information and the supporting administrative, reporting and training arrangements to ensure the information is of consistently high quality.
- 4.2 Written procedures will be available in all relevant locations within the CCG to assist staff in collecting and recording data. These procedures will be kept up-to-date, and where appropriate will also contain information relating to national data definitions.
- 4.3 Processes will be established to ensure compliance with the procedures, which will include sample checks to audit compliance.
- 4.4 It should be noted that all collection, storage, processing and reporting of personal information is governed by detailed legal requirements under the Data Protection Act 2018 and associated standards, such as the Caldicott2 guidelines and Health and Social Care Act 2012. The introduction of the General Data Protection Regulation (GDPR) in 2018 and the National Data Guardian Review resulted in further requirements for implementation.
- 4.5 As the CCG generates a very wide range of information for a whole variety of uses, this policy does not provide detailed guidance for specific data items or individual areas of application. It concentrates instead on general principles of completeness, accuracy, ongoing validity, timeliness, consistency of definitions and compatibility of data items, and signposts where specific procedures or further guidelines need to exist.

## **5. GENERAL PRINCIPLES**

The following overarching principles underpin the approach to data quality:

- 5.1 All staff will conform to legal and statutory requirements and recognised good practice, aim to be significantly above average on in-house data quality indicators, and will strive towards 100% accuracy across all information systems.
- 5.2 All data collection, manipulation and reporting processes by the CCG will be covered by clear procedures which are easily available to all relevant staff, and regularly reviewed and updated.
- 5.3 All staff should be aware of the importance of good data quality and their own contribution to achieving it and should receive appropriate training in relation to data quality aspects of their work.
- 5.4 Teams should have comprehensive procedures in place for identifying and correcting data errors, such that information is accurate and reliable at time of use.

## **6. PERSON IDENTIFIABLE DATA (PID)**

6.1 Person Identifiable Data (“PID”) may only be processed and used in the following circumstances:

- For Primary Uses (i.e. direct healthcare purposes)
- Where the patient’s explicit consent to process PID has been gained
- Where the processing of PID is covered by legislation
- In exceptional circumstances, where processing is justified in the public interest
- Where a Section 251 approval has been gained for the processing of PID

Where data is to be used for Secondary Uses (i.e. for non-direct healthcare) and there is no legal basis to disclose PID, data must be pseudonymised or anonymised.

PID - Any information that can identify an individual. This could be one piece of data, for example, a person’s name or a collection of information, for example, name, address and date of birth.

Secondary Uses – Is basically anything outside of direct patient care. When information is processed for non-healthcare and medical purposes. Generally, this could be for research purposes, audits, service management, commissioning, contract monitoring and reporting facilities.

## **6.2 Pseudonymised Data**

Pseudonymised (or key-coded) data is used to mask the identity of patient data when it is shared with persons for secondary uses. A unique identifier is used and only those with the 'key' can track back to the patient's details. A typical pseudonym will replace the NHS number with an alternative unique number

Data which includes the date of birth and the postcode is not suitable for pseudonymisation and therefore should not be used in their raw format.

- Dates of birth are difficult to pseudonymise because of the very limited range - replace with age, or month and year, or use age bands.
- Postcodes can be too specific, replace with postal town, or the first part of the postcode only.

## **6.3 Security**

Pseudonymisation is not a method of anonymisation. Pseudonymised data must be treated as PID and be secured appropriately. A data sharing agreement must be in place when pseudonymised information is to be transferred to a third party.

## **6.4 Anonymised Data**

Anonymisation is the process of turning data into a form that does not identify individuals and where identification is not likely to take place. This allows for a much wider use of the information. An example is where data has been aggregated.

## **7. RESPONSIBILITY AND ACCOUNTABILITY FOR DATA QUALITY**

- 7.1 Data quality is a key part of any information system that exists within a CCG. All staff members will be in contact at some point with a form of information system, whether paper or electronic. As a result, all staff members are responsible for implementing and maintaining data quality and are obligated to maintain accurate information legally (Data Protection Act), contractually (contract of employment) and ethically (professional codes of practice).
- 7.2 Accountability for an individual dataset may change during business process but the team designated as the key team, has overall responsibility for any data quality issues to date.
- 7.3 In the event of there being no identified key team then the team responsible for any errors will be responsible for rectifying them.
- 7.4 It is the responsibility of all managers to ensure that, where appropriate, systems are in place to validate the completeness, accuracy, relevance and timeliness of data/information. Managers must ensure that all staff are fully aware of their obligations in this area. In certain circumstances, to support equality and diversity, line managers will need to consider individual requirements of staff to support good practice in complying with this policy.
- 7.5 Ultimate responsibility for maintaining accurate and complete data and information lies with the Chief Finance Officer but all staff who record information, whether on

paper or by electronic means, have a responsibility to take care to ensure that the data is accurate and as complete as possible. Individuals with responsibility for data quality must have this clearly stated in their job descriptions.

- 7.6 All information assets of the CCG must be identified and have a nominated Information Asset Owner (IAO). Accountability for assets helps to ensure that appropriate protection is maintained. Senior Information Risk Owners should ensure owners are identified for all Information Assets with responsibility for managing the risks to those assets. Whilst responsibility for implementing and managing Information Asset controls may be delegated to Information Asset Administrators or equivalent, accountability should remain with the nominated owner of the asset. (IGT)

<p><b>Accountable Officer</b> Has overall responsibility for ensuring that information risks are assessed and mitigated to an acceptable level. Information risks should be handled in a similar manner to other major risks such as financial, legal, and reputational risks.</p>	<p><b>Chief Finance Officer</b></p>
<p><b>Senior Information Risk Owner (SIRO)</b> Provides the focus for the assessment and management of information risk at Board level, providing briefings and reports on matters of performance, assurance and cultural impact. Should oversee a review of the asset register to ensure it is complete and robust.</p>	<p><b>Board level SIRO</b></p>
<p><b>Information Asset Owners (IAO)</b> Each Information Asset Owner should be aware of what information is held and the nature and justification of information flows to and from the assets they are responsible for. The role is to understand and address risks to the information assets they 'own' and provide assurance to the SIRO on the security and use of these assets.</p>	<p><b>Directors/Senior Leadership Team members</b></p>
<p><b>Information Asset Administrators (IAA)</b> Provide support to their IAO. Ensure that policies and procedures are followed. Recognise potential or actual security incidents. Consult their IAO on incident management. Ensure that information asset registers are accurate and maintained up to date.</p>	<p><b>Operational staff responsible for one or more assets</b></p>

## **8. TRAINING**

Staff will receive instruction and direction regarding Data Quality advice and information from:

- CCG Policies and Procedure Manuals;
- Line manager;
- Training – on induction, and Information Governance training;
- Other communication methods (e.g. Team Brief/team meetings);
- CCG Extranet.

## **9. EXTERNAL SOURCES OF DATA**

Where possible validation processes should use accredited external sources of information e.g. using Patient Demographic Service (PDS) to check NHS numbers, National Administrative Codes Set (NACS) to check organisation/GP codes, Exeter system to check deaths. The CCG will use external sources of data to improve data quality e.g. SUS data quality dashboards on a regular basis to check comparative data and identify previously unidentified issues. Staff involved with recording data need to ensure that it is performed in a timely manner and that the details being recorded are checked with the source at every opportunity. This could be by cross checking with patient paper records or by asking the patients themselves when direct contacts occur.

The NHS number is the main patient identifier and must be recorded correctly and, in all systems, where patient information is present. The NHS number should be used in all referral forms and letters. The Information Governance (up to version 14.1 March 2018) toolkit required evidence that the NHS number was used and a mandatory NHS number field in all documentation and systems.

## **10. AUDIT OF SERVICE USER DATA**

As a commissioning organisation, service user data may only be held by CCG Teams involved in commissioning or delegated public tasks eg Patient Experience; Continuing Healthcare; Exceptional Cases Teams. Each of these teams has a process in place to sample audit the integrity of service user data held within their electronic systems and report their findings to the Information Governance Team monthly. Where errors are identified during audit, they must be verified and corrected immediately. CCG staff members who have contact with service users or their representatives, are required to ensure that all details held are accurate and up to date during that contact.

## **11. MONITORING**

11.1 The CCG, will as a matter of routine, monitor performance in collecting and processing data according to defined standards, and provide appropriate feedback to staff involved in the process of data collection.

11.2 The CCG will be regularly audited as part of ASH accreditation to ensure that:

- Applicable legislative Acts are complied with;
- NHS and CCG Policies and Standards are complied with;

- Suitable processes are used, and controls put in place, to ensure the completeness, relevance, correctness and security of data.

## **12. DATA QUALITY STANDARDS**

Although there are many aspects of good quality data, the key indicators commonly are:

- Validity – All data items held on the CCGs computer systems must be valid. Where codes are used, these will comply with national standards. Wherever possible, computer systems will be programmed to only accept valid entries.
- At data input – Data accuracy is the direct responsibility of the person inputting the data supported by their line manager.
- Systems will include validation processes at data input to check in full or in part the acceptability of the data wherever possible. Depending on the system, later validation may be necessary to maintain referential integrity.
- Completeness – All mandatory data items within a dataset should be completed. Use of default codes will only be used where appropriate, and not as a substitute for real data.
- Consistency – Correct procedures are essential to ensure complete data capture.
- Coverage – this reflects all information that is ‘owned’ by the CCG, including paper and computerised records.
- Accuracy – Data recorded manually and on computer systems must be accurate.
- Relevance – Information should be contextually appropriate.

## **13. VALIDATION METHODS**

Validation should be accomplished using some or all of the following methods:

- 13.1 On submission of data returns, procedures will exist to ensure the completeness and validity of the data sets used. This can be done by comparing to historical data sets, looking at trends in the data and also by cross checking the data with other staff members.
- 13.2 Regular spot checks by staff members; which involve analysis of a random selection of records against source material, if available. Spot checks should be done on an ongoing basis (at least quarterly) to ensure the continuation of data quality.
- 13.3 The CCG will endeavour to ensure that timescales for submission of information are adhered to, and that the quality and accuracy of such submissions is of the highest standard. Internal deadlines for the completion of data sets, to ensure national timescales are achieved, will be explicit and monitored.
- 13.4 The CCG routinely receives activity information from its service providers. This information is used to monitor the performance of contracts and to contribute to the service planning and development process. Sufficient and appropriate checks are made by the service providers to ensure that the information received is accurate and complete. Where data falls outside anticipated ranges a more detailed evaluation and validation is undertaken.

13.5 The CCG conducts regular monthly Technical Group meetings with its local trusts, to ensure that any data discrepancies are picked up and any corrections are made as required.

#### **14. IMPLEMENTATION OF THE POLICY**

The Chief Finance Officer will have overall responsibility for implementing the Policy ensuring that the following action is taken:

- That the CCG's IG, BI and IM&T Steering Group review the Policy bi-annually so that it continues to reflect best practice and the legal and business needs of the CCG;
- That the Policy is promoted and circulated appropriately within the CCG;
- Training needs are assessed and agreed during induction and appraisal processes;
- Monitoring and Audit to be identified and completed at appropriate intervals.

## ANNEX A – Equality Impact Assessment Form

### Equality Impact Assessment Form

#### Initial Screening

<b>Name of Proposal (policy/strategy/function/service being assessed)</b>	CCG Data Quality Policy 2021-2023
Those involved in assessment:	Policy developed in consultation with the IG, BI & IM&T Steering Group and for endorsement by the Integrated Performance and Assurance Committee
Is this a new proposal?	No.
Date of Initial Screening:	updated April 2021

What are the aims, objectives?	This Policy will set out a clear policy framework for maintaining and increasing high levels of data quality within the CCG. The CCG will routinely monitor performance in collecting and processing data according to defined standards and provide appropriate feedback to staff involved in the process of data collection.
Who will benefit?	All CCG staff Service Users
Who are the main stakeholders?	Staff, Managers, IG, BI, IM&T Steering Group, Service Users
What are the desired outcomes?	Staff awareness of the CCG Policy. To record and present data of a high quality and accuracy.
What factors could detract from the desired outcomes?	Lack of awareness of the existence of the Policy. Failure to follow the Policy/procedure.
What factors could contribute to the desired outcomes?	Knowledge of the policy and implementation of the policy
Who is responsible?	All staff and IG, BI, IM&T Steering Group

Have you consulted on the proposal? If so with whom? If not, why not?	Policy developed in consultation with the IG, BI & IM&T Steering Group for approval and endorsement by the Integrated Performance and Assurance Committee

Which protected characteristics could be affected and be disadvantaged by this proposal (Please tick)		Yes	No
Age	<u>Consider:</u> Elderly, or young people		x
Disability	<u>Consider:</u> Physical, visual, aural impairment, Mental or learning difficulties		x
Gender Reassignment	<u>Consider:</u> Transsexual people who propose to, are doing or have undergone a process of having their sex reassigned		x
Marriage and Civil Partnership	<u>Consider:</u> Impact relevant to employment and /or_training		x
Pregnancy and maternity	<u>Consider:</u> Pregnancy related matter/illness or maternity leave related mater		x
Race	<u>Consider:</u> Language and cultural factors, include Gypsy and Travellers group		x
Religion and Belief	<u>Consider:</u> Practices of worship, religious or cultural observance, include non-belief		x
Sex /Gender	<u>Consider:</u> Male and Female		x
Sexual Orientation	<u>Consider:</u> Know or perceived orientation		x

**What information and evidence do you have about the groups that you have selected above?**

The above protected characteristics will have no adverse impact as the Policy has been developed in accordance with new Data Protection legislation (ie General Data Protection Regulation May 2018).
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Consider: Demographic data, performance information, recommendations of internal and external inspections and audits, complaints information, JNSA, ethnicity data, audits, service user data, GP registrations, CHD, Diabetes registers and public engagement/consultation results etc.

**How might your proposal impact on the groups identified? For example, you may wish to consider what impact it may have on our stated goals: Improving Access, Promoting Healthy Lifestyles, Reducing Health Inequalities, Supporting Vulnerable People**

Examples of impact re given below:

- a) Moving a GP practice, which may have an impact on people with limited mobility/access to transport etc
- b) Planning to extend access to contraceptive services in primary care without considering how services may be accessed by lesbian, gay, bi-sexual and transgender people.
- c) Closure or redesign of a service that is used by people who may not have English as a first language and may be excluded from normal communication routes.

Please list the positive and negative impacts you have identified in the summary table on the following page.

<b>Summary</b>	
Positive impacts (note the groups affected)	Negative impacts (note the groups affected)

Summarise the negative impacts for each group:

N/A

**What consultation has taken place or is planned with each of the identified groups?**

Policy was developed and approved in consultation with the IG, BI and IM&T Steering Group prior to endorsement by the Integrated Performance and Assurance Committee.

What was the outcome of the consultation undertaken?

Approval and Endorsement sought

**What changes or actions do you propose to make or take as a result of research and/or consultation?**

N/A

**12.1 Will the planned changes to the proposal?**

Please State  
Yes or No

a) Lower the negative impact?	N/A
b) Ensure that the negative impact is legal under anti-discriminatory law?	N/A
c) Provide an opportunity to promote equality, equal opportunity and improve relations i.e. a positive impact?	N/A

**Taking into account the views of the groups consulted and the available evidence, please clearly state the risks associated with the proposal, weighed against the benefits.**

N/A

**What monitoring/evaluation/review systems have been put in place?**

Monitoring will be undertaken by the Business Intelligence Team. The frequency will be every other year or as a required in line with local or national requirements.

**When will it be reviewed?**

May 2023

<b>Date completed:</b>	16 April 2021
<b>Signature:</b>	Associate Director of Business Analytics
<b>Approved by:</b>	OD & HR Advisor (Equality & Diversity)
<b>Date approved:</b>	23 April 2021