Data Quality Policy

Version No: 1

Document Summary:

This document reinforces Mersey and West Lancs Teaching Hospitals commitment to data quality. The Policy is intended to cover all data that is entered onto computerised systems within the Trust. It primarily covers data relating to patients and the delivery and recording of their care, but can also include other data that relates to financial management, service management and performance.

Document status	Approved	
Document type	Policy	**Trust wide**
Document number	PD0129	
Approving body	Information Steering group	
Date approved	06/06/2025	
Date implemented	06/06/2025	
Review date	***3 years from approval date 06/06/2028**	
Accountable Director	Director of Informatics	
Policy Author	Senior Clinical Information and Data Quality Manager	
Target audience	All staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as “uncontrolled”, as they may not contain the latest updates and amendments

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information

Title	Data Quality Policy
Directorate	Corporate

Brief Description of amendments

Updated for Mersey West Lancs combined Trust

Please state if a document has been superseded.

Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes
Data Protection Impact Analysis completed?	Yes

Section 2 – Consultation Information*

*Please remember to consult with all services provided by the Trust, including Community & Primary Care

Consultation Completed	☐ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	Click here to enter a date.	**Consultation end date**	Click here to enter a date.

Section 3 – Version Control

Version	Date Approved	Brief Summary of Changes
1	09/05/2025	Reviewed and harmonised for use by the whole of MWL
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	

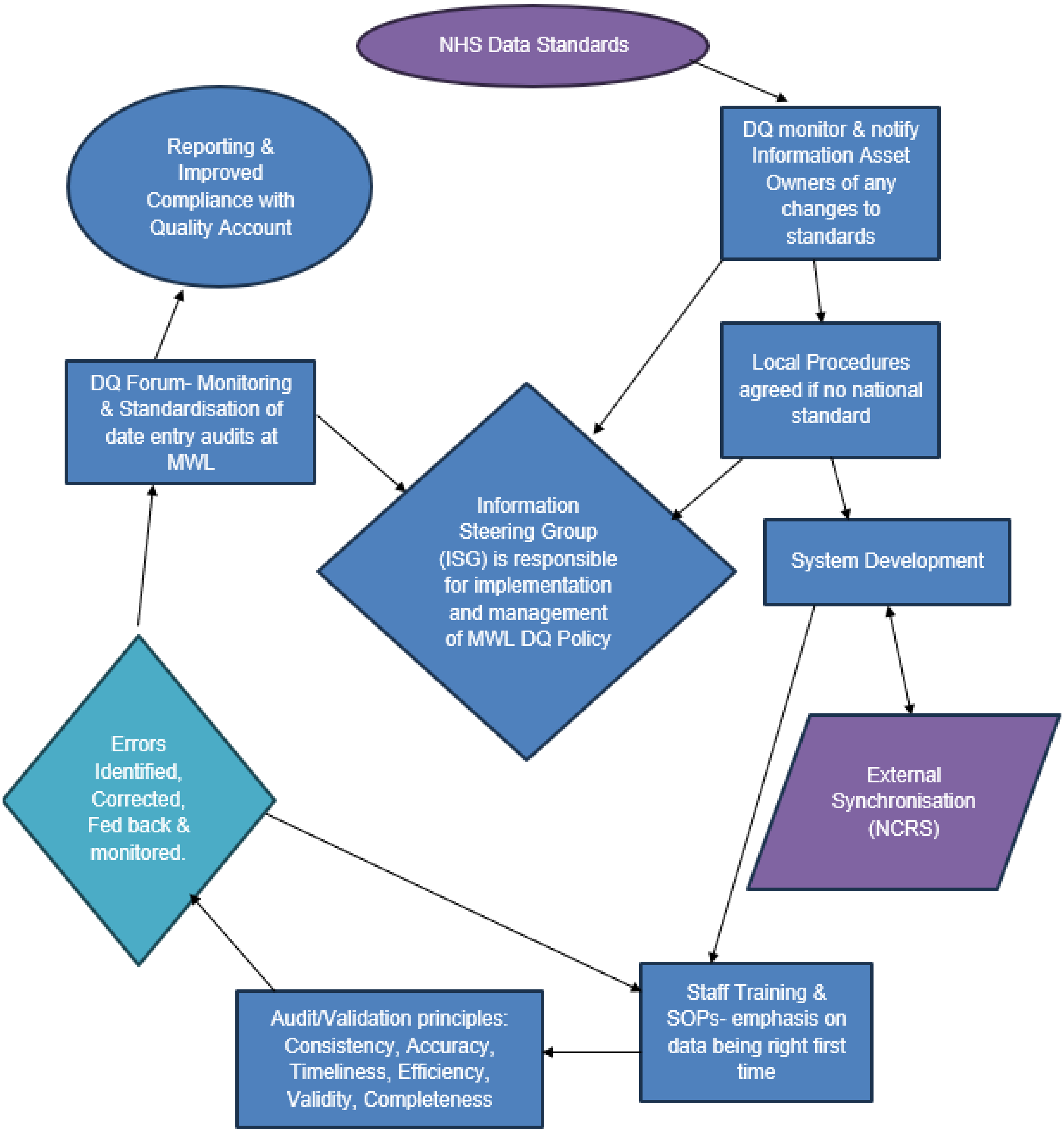
Section 4 – Approval – *To be completed by Document Control*

Document approved	☒ Approved ☐ Approved with minor amendments		
Assurance provided by author & Chair	☒ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	06/06/2025	**Review date**	06/06/2028

Section 5 – Withdrawal – *To be completed by Document Control*

Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval
Date Withdrawn:	Click here to enter a date.

Quick Reference Guide


NHS Data Standards
DQ monitor & notify Information Asset Owners of any changes to standards
Reporting & Improved Compliance with Quality Account
Local Procedures agreed if no national standard
DQ Forum- Monitoring & Standardisation of date entry audits at MWL
Information Steering Group (ISG) is responsible for implementation and management of MWL DQ Policy
System Development
Errors Identified, Corrected, Fed back & monitored.
External Synchronisation (NCRS)
Staff Training & SOPs- emphasis on data being right first time
Audit/Validation principles: Consistency, Accuracy, Timeliness, Efficiency, Validity, Completeness

Contents

1. Scope

The policy is intended to provide a framework for all MWL staff working across the Trust including bank & agency staff, volunteers or sub-contractors. This policy is applicable to all staff who collect, record, use, change and share data. The scope of this policy includes all types of data recorded digitally and on hard copy within the Trust, on all information assets, including electronic patient administration systems and clinical information records. It encompasses all data created by the organisation, including that relating to service users, staff information, financial management, information governance and service and performance management.

2. Introduction

Good policy management underpins all clinical and non-clinical processes within the Trust to ensure they are consistent, effective and safe. This policy sets out the Trust requirements when collecting, recording, using, changing and sharing data to ensure consistency in quality and compliance.

The purpose of the policy is to ensure data quality standards are adhered to and there is a commitment to continual improvement and the maximisation of the accuracy, timeliness and quality of data recorded

3. Statement of Intent

High quality data is a vital pre-requisite to ensuring the Trust conducts business efficiently, delivers safe and effective care to patients and achieves key performance indicators. Trusts are increasingly finding that the quality of the services they offer to patients are viewed not only on outcomes but also on the data entered onto their IT systems.

Data quality underpins Clinical, Research, and Information Governance, as well as Management, Planning and Accountability within the Trust. More specifically, data quality is essential for-

- Efficient delivery of patient care e.g. by ensuring patients are given appointments and admission dates based on clinical priority and length of waiting time.
- Clinical governance and minimising clinical risk e.g. wrong patient, wrong treatment.
- Trust Income under the NHS Payment System, to ensure that the correct level of payment is secured from Commissioners and to monitor performance against Service Level Agreements.
- Improved decision making, as operational and strategic decisions are made based on quality information.
- Performance measurement, allowing MWL to monitor and evaluate performance locally and nationally, taking action when necessary.
- Clinical audit and research and development, with a view to improving patient care in the future.
- To meet the statutory needs of Commissioners and the Department of Health and to meet the needs of the public, under the Freedom of Information Act.

Poor data quality could lead to the Trust –

- Weakening frontline service delivery

- Compromising patient safety
- Incurring financial loss
- Providing poor value for money
- Damaging stakeholder trust

The fundamental principle of data quality is that data should be right first time and therefore the emphasis is on reducing errors at the point of data entry as well as divisional ownership and personal responsibility.

The Trust applies the principles of consistency, accuracy, timeliness, efficiency, validity and completeness of data to ensure high data quality. This policy will further detail the principles of data quality. It will explain the roles and responsibilities of all staff and how the policy will be implemented to ensure data in the Trust is of a high standard. This policy is influenced by the data quality requirements set out by the Care Quality Commission, NHS Digital, NHS Improvement and the Data Security & Protection Toolkit.

4. Definitions

Term/Abbreviation	**Definition/meaning**
Key Performance Indicators (KPI)	A quantifiable measure used to evaluate the success of an organization, employee, etc. in meeting objectives for performance.
Information Asset Owner	An individual within an organisation that has been given formal responsibility for the security of an asset (or assets) in their particular work area.
Data Alliance Partnership Board	A new governance structure has been put in place to provide oversight of the assurance and approval of information standards, data collections and data extractions across health and adult social care.
National Care Records Service (NCRS)	An electronic record of important patient information, created from GP medical records. They can be seen and used by authorised NHS staff directly involved in the patient's care using the NCRS application. Health and care staff can access NCRS through the Spine web portal login.

5. Duties, Accountabilities and Responsibilities

In order to achieve consistently high standards of data quality there is clear corporate leadership within MWL combined with a comprehensive management and accountability framework focused on achieving good data quality.

Role	Responsibilities
Director of Informatics	• The Director of Informatics (SIRO) will advise the Trust regarding information risks and will provide advice to the Chief Executive in regard to any information risk.

	• Will ensure that the Trust Board is kept informed regarding information security risks and how they are managed. All information assets of the Trust must be identified and have a nominated Information Asset Owner (IAO). • Responsible for ensuring there is a fit for purpose Patient Administration System (PAS) and that staff are appropriately trained in its use.
Head/ Deputy Head of Departments	• Responsible for providing guidance on data definitions across a range of data collection processes and advises on data quality improvements or changes necessary for reporting on the current statutory reporting measures. • Support with communicating Information Standards Notifications to leads in the relevant key areas for implementation. • Lead for ensuring that appropriate data quality performance monitoring reports are made available to the Board via the Governance structure for assurance and improvement purposes.
Information Asset Owner (IAO)	• Responsible for ensuring they are satisfied that data quality processes facilitate the collection of high quality data in accordance with national standards for the systems they are asset owners for. • The nominated Senior Responsible Person is responsible for monitoring and disseminating changes that are directed by external controls. Monitoring reports must be created and disseminated to appropriate staff and services detailing key quality issues.
Information Steering Group (ISG)	• The ISG is a governance group reporting to the executive committee in support of clinical and managerial requirements of the Trust. • The group aims to provide a robust and qualitative foundation for information management. It is responsible for the implementation and management of the Trust’s Data Quality policy and the monitoring of the timeliness and completeness of the activity recorded.
Patient Tracking Group	• This group is responsible for monitoring the Trust’s Data Quality reports.
Line Managers	• Responsible for ensuring adherence to this policy by monitoring the accuracy of patient data in their local systems. • Responsible for identifying the training needs of their staff and for liaising with the trainers to ensure these needs are met. Staff who enter information onto electronic systems must be suitably trained and have an understanding of the consequences of the non-collection of data. Staff will not be given access to an electronic system until they have attended the relevant training session. • Further training regarding data quality should be given by the relevant senior member of staff within the department to re-enforce and support the training given by the IT training team. • Responsible for ensuring all staff within their remit are familiar with the SOP’s (Standard Operating Procedures) relevant to their area of work.

	• The importance of achieving good data quality will be addressed with all relevant staff as part of their induction into their individual department. • Must act appropriately on any data quality issues in a timely manner.
IT Training Team	• Provide training on a number of Trust electronic systems at the request of a senior member of the department in which the staff are employed. • Also responsible for providing update training when there has been any significant enhancement or change to the system that may affect the collection and recording of information. Where there are minor enhancements or changes to a system the change will be communicated by global e-mail.
Individual Trust Staff	• All staff must ensure they take appropriate care when recording, updating or validating patient information or data. • Ensure that they understand and apply the procedures relevant to their area of work. • They must have a clear understanding of the direct impact incorrect information can have on patient care and raise concerns with their line manager when issues that may compromise the recording of accurate and timely information are identified. • Ensure all data is processed in a secure and confidential way to comply with General Data Protection Regulation standards and the Trust Confidentiality Policy • Where the data is in written or printed form, care must be taken to use this data appropriately and to dispose of the data after use in a confidential manner.
Data Quality Team	• The Data Quality Team amends inaccuracies that cannot be corrected at source. • Interpret requirements of the Data Dictionary to support with ensuring compliance of Trust national data set. • Be aware of and comply with legislation and Trust policies and procedures. • Work in partnership with clinical services to improve data quality • Escalate key data quality issues to relevant managers where appropriate. • Provide awareness sessions were appropriate.

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust ensuring that Trust policies comply with all legal, statutory and good practice guidance requirements to facilitate recording and monitoring of accurate and complete data.

6. Data Quality Principles

All staff involved in the entry of data to the Trust Administration System and other Trust systems must ensure that the information recorded complies with the data quality principles outlined below-

- **Consistency**: Stable and consistent data collection processes must be in place across collection points and over time, so that managers and stakeholders can be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.

- **Accuracy**: Data recorded on paper and on computer systems must accurately reflect the event or individual associated with the data. Every opportunity shall be taken by staff to check demographic details with patients at point of contact.
- **Timeliness**: Data must be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period.
- **Efficiency**: Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
- **Validity**: Data must be validated and updated on the source system to ensure consistency and to maintain the integrity of electronic data. Data should comply with standard national codes. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk.
- **Completeness**: All available fields must be populated where the data is known and available to the individual. As well, all records for a relevant population must be provided for a submission to be complete.

6.1 Process

NHS Data Standards

The NHS Data Dictionary gives common definitions and guidance to support the sharing, exchange and comparison of information across the NHS. It is the definitive reference point for assured information standards which make up the base currency of Commissioning Data Sets. The Commissioning Data Sets are maintained and developed by NHS Digital, in accordance with the needs of the NHS and the Department of Health and Social Care. Commissioning Data Sets form the basis of data on activity carried out by organisations reported centrally for monitoring and payment purposes.

Governance

The NHS communicates new standards and changes to current data standards, collectively known as information standards, data collections and data extractions (ISCE). These changes are monitored by the Data Quality team using the Data Alliance Partnership Board (DAPB) which manages the release of ISCEs. The Data Quality team will notify the relevant Information Asset Owner who is responsible for ensuring data and information systems to which the ISCEs apply are compliant. The governance arrangement for monitoring of the ISCEs goes through the Information Steering Group (ISG).

Where there is no applicable NHS standard, the Trust will agree local standards and definitions which are reviewed annually for validity and relevance. These local standards will be in line with new and existing contracts. These will also be monitored through a similar governance arrangement through the ISG.

DQ Forum

The Data Quality (DQ) Forum will provide oversight to ensure the timely completion of data quality checks across departments in the Trust.

As part of the Quality Account, the Trust is required to carry out data quality checks within each department and evidence these. The data quality checks encompass any data entry audits, where the data entered by teams is checked to ensure it has been recorded correctly.

The DQ Forum sets out to achieve improved data quality across the Trust and ensure compliance with the Quality Account and Data Quality policy.

This will be achieved through-

- Standardisation of data entry auditing completed across departments
- Monitoring of the completion of data entry audits across departments
- Collation of evidence of audit completion and timely submission to the Quality Account
- Feedback on audit outcomes to members of the group
- Highlighting of potential training areas to the relevant members of the group

The group reports directly up to the Information Steering Group (ISG).

Audit

The Information Asset Owner and departmental leads are responsible for identifying trends in data quality issues and taking steps to amend processes to reduce errors.

Validation must be performed by both administration and operational staff. It is imperative that regular validation processes are undertaken on data being recorded to assess its consistency, accuracy, timeliness, efficiency, validity and completeness.

Errors or omissions that are identified as a result of audits undertaken will be output to data quality reports which in turn will be fed back to the operational services for amendment. They must be amended as soon as possible after they have been identified in line with national and local policies, procedures and SOPs relating to correction of records.

Where there is a pattern of such errors or omissions with particular staff, the potential consequences must be considered and due regard paid to patient safety. Managers must follow appropriate processes- to protect patients and ensure data quality- including capability or disciplinary procedures as appropriate.

Validation of Clinical Coding

The Clinical Coding Department undertake regular internal clinical coding audits and the Records Management Project undertakes in-depth reviews of documentation and assigned clinical codes with the clinicians. This information is documented and fed back to the clinicians and the Records Management Board.

There is a robust mechanism of clinical engagement and a number of validation pathways in operation to ensure the quality of the clinically coded data in line with Data Security Protection Toolkit.

External Sources of Data

The validation process must use the National Care Records Service (NCRS). The NCRS is an accredited external source of information which provides a quick and secure way to access patient demographic information, e.g. NHS number, to improve clinical decision making and healthcare outcomes.

In situations where data is shared between systems it is imperative that there is a robust synchronisation when data is entered or amended on an electronic system and that is validated first. Any modifications made must be shared with other related systems ensuring there are no inconsistencies between them. Continuous synchronisation between systems is required to guarantee that all data sources reflect the same information.

Line managers are encouraged to provide staff with smart cards and equipment that are Personal Demographic Service (PDS) enabled to reduce data input errors and support data synchronisation and flow.

Data Use & Reporting

All NHS Trusts send patient data to the national database Hospital Episode Statistics (HES) via the Secondary Uses Service (SUS). The Trust submits data centrally for the national key datasets, Admitted Patient Care, Outpatients, Emergency CDS, Community CDS and Maternity CDS to the Secondary Uses Service on a weekly basis. The Secondary Uses Service (SUS) is a single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. This information is used nationally for many purposes including NHS England analysis and reporting, extracts for Commissioners to support contract monitoring, the Care Quality Commission and HED extracts for benchmarking analysis.

Compliance with national standards is therefore essential, as Trusts are measured on completeness and validity of the data that they produce. The Secondary Uses Services process the data using specific methodology and rules and so incomplete records are rejected if not compliant. As the data submitted centrally to the Secondary Uses Service is of high importance the Trust's data quality improvement programme is focussed on improving specific data items across the key datasets. This is monitored through the Data Quality Maturity Index (DQMI) which is presented to the Information Steering Group (ISG). The DQ MI is a monthly publication providing data submitters with timely and transparent information about their data quality in comparison to national averages.

Data quality checks and balances are performed when preparing reported information particularly those that are being shared externally. All statutory reports undergo accuracy and validity checks prior to executive sign off.

6.1.1 Implementation

This policy will be available on the Trusts intranet and internet site. It will be disseminated through the management structure and implementation will be monitored in each department through effective individual staff performance measurement.

The Trust discourages the retention of hard copies of the policy and can only guarantee that the policy on the Trust intranet is the most up to date version.

7. Training

The training at MWL will be tailored to the primary objective of staff getting it right first time. To achieve this the Trust will have a formal and ongoing programme of training, which will be periodically evaluated and adapted to respond to changing needs.

Adequate training should be undertaken prior to staff members commencing their duties and it is the responsibility of all managers to ensure this training takes place. Similarly temporary staff including agency or bank staff should receive the relevant training to undertake a role prior to inputting any data into Trust clinical systems.

The table below identifies the training which staff require to enable implementation of this policy:

If necessary, further training or support in the workplace will be given to reduce the number of errors made. It is recommended that line managers conduct refresher training annually on departmental and data quality policies.

A training needs analysis can be used to identify any knowledge gaps or refresher training requirements. See Appendix 1 for further details.

What aspect/s of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Statutory & Mandatory Training Policy?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
Information Governance	All staff	Yes	E-Learning	Self learning	Induction/ annually	Line Managers
ESR/ Health Roster	All relevant staff	No	E Learning	Self learning	Ad hoc	Line Managers
Careflow	All relevant staff	Yes	E Learning	IT trainers	Induction/ Ad Hoc	Line Managers IT trainers
Vitals	All relevant staff	Yes	E Learning	System Trainers	Induction/ Ad Hoc	Line Managers System Trainers
Evolve/ EDMS	All relevant staff	Yes	E Learning	IT trainers	Induction/ Ad Hoc	Line Managers IT Trainers

EMIS	All relevant staff	No	E Learning	System Trainers	Ad Hoc	Line Managers IT Trainers

8. Monitoring Compliance

Monitoring compliance with this document will be overseen by the ISG.A number of the Trust's Data Quality reports will be circulated so the progress and accuracy of data quality can be monitored. Errors and omissions will be investigated by the relevant members of the group so that training issues can be addressed within specific teams or with relevant persons. The group will also have to access to reports on an ad hoc basis to aid them in the performance management of their staff groups.

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	Duties are carried out as described in the policy
2.	Compliance will be monitored via the Information Steering Group These will be monitored by a suite of reports.
3.	External Audit Rating to be of an acceptable standard.

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Refer to KPIs	Senior Clinical Information and Data Quality Manager	Spot checks Data Quality Framework Reports External Audit Reports	Monthly	Information Steering Group Trust Board Audit Committee	Relevant departmental manager Clinical Information and Data Quality Manager

9. References/Bibliography/Relevant Legislation/National Guidelines

No	Reference
1.	Data Security and Protection Toolkit- https://www.dsptoolkit.nhs.uk/
2.	Data Alliance Partnership Board- https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/data-alliance-partnership-board
3.	NHS Digital- information standards, data collections and data extractions- https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections
4.	Data Dictionary- https://www.datadictionary.nhs.uk/

5.	Data Quality Maturity Index (DQMI)- Data quality - NHS England Digital

10. Related Trust Documents

[List any procedural documents which are referenced within the text.]

No	Related Document
1.	Information Governance Policy- https://intranet.sthk.nhs.uk/extranet/widget/policies/download/2022-61d6e8f7953815.83611778
2.	MWL Digital Strategy- https://intranet.sthk.nhs.uk/extranet/widget/policies/download/2022-61d6e833168740.53685144
3.	Management of Health Records Policy- https://intranet.sthk.nhs.uk/extranet/widget/policies/download/2022-61d7223c966738.07281995
4.	Confidentiality Code of Conduct Policy- https://intranet.sthk.nhs.uk/extranet/widget/policies/download/2021-61c4808bae1026.38752156

11. Equality Impact Assessment (EIA) Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the beginning of the planning stage of any change process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to PatientEDI@sthk.nhs.uk for monitoring purpose for EIAs carried out on patient related functions.
If the assessment is related to workforce a copy should be sent to workforceedi@sthk.nhs.uk

If this screening assessment indicates that discrimination could potentially be introduced, then seek advice from the Head of Patient Experience and Inclusion via cheryl.farmer@sthk.nhs.uk for patient related functions or Head of Workforce Equality Diversity and Inclusion via darren.mooney@sthk.nhs.uk for workforce related functions.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Information
Brief description of function to be assessed	This policy defines how the Trust ensures data quality standards are adhered to and there is a commitment to continual improvement and the maximisation of the accuracy, timeliness and quality of data recorded
Date of assessment	06/06/2025

Lead Executive Director	Darran Hague, Director of Information
Name of assessor	Anna Lovell
Job title of assessor	Clinical Information and Data Quality Manager

1. Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to discriminate against equality groups or people in inclusion health groups
2) Promote equality of opportunity, or foster good relations between those who share a protected characteristic and those who don't?
3 Where there is potential unlawful discrimination, is this justifiable?

Please tick the relevant box

	Positive impact	**Negative impact**	**No impact**	**Justification/ evidence**
Age			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Disability			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Gender reassignment			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Pregnancy or maternity			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Race			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Religion or belief			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Sex			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Sexual orientation			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.

2. Human Rights

Does the policy/proposal breach the Human Rights of individuals or groups?

	Yes	**No**	**Justification/ evidence**
Right to life		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Inhumane treatment		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Liberty		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Privacy/family life, home and correspondence		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Thought/conscience		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Freedom of expression		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Right to a fair trial		x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.

3. Health Inequalities

Is there potential that the policy/proposal could have a negative impact on inclusion health groups?

Is the policy/proposal addressing health inequalities? Where there are potential unlawful impacts are they justifiable.

	Positive Impact	Negative Impact	No impact	Justification/ evidence and data source
Deprived Populations			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.
Inclusion health groups			x	The policy governs how we ensure data quality standards are met. This will not have an impact on these characteristics.

4. Sign off

Name of approving manager	Anna Lovell
Job title of approving manager	Clinical Information and Data Quality Manager
Date approved	06/06/2025

5. EIA Action Plan

Recommendations	Actions Required	Resources required /costs	Timeframe	Lead officer responsible

Please forward an electronic copy of this action plan with the completed assessment to , Cheryl.farmer@sthk.nhs.uk for patient related assessments or equality&diversity@sthk.nhs.uk for workforce related assessments for monitoring purposes.

12. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		x		
Will the procedural document lead to the collection of new information about individuals?		x		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		x		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		x		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		x		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		x		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		x		
Will the implementation of the procedural document compel individuals to provide information about themselves?		x		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author: Senior Clinical Information and Data Quality Manager Date: 06/06/2025

13. Appendix 1 – Training Needs Analysis Form

If training is required, please consider the following: who needs the training (and how often); who will deliver it and how will they do this (e.g. duration/ location); what are the objectives it will meet and how will you assess learner competence; how quickly do staff need to be trained and do we have the resources to deliver this; are there any funding implications; where will completion of this training be recorded (and who will do this).

Staff Role	Training Requirement	Frequency	Training Delivery Method