HYWEL DDA UNIVERSITY HEALTH BOARD

Health Records Management Strategy

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Brief Summary of Document:	This strategy addresses the principles and practice for managing health records within Hywel Dda University Health Board.
Scope:	This strategy was written to provide professional advice and guidance for Hywel Dda University Health Board to ensure compliance with all legal requirements for the maintenance, storage and provision and security of records. Identifying key individuals within the Health Board and their obligation to ensure records are managed in accordance and legal requirement and both national and local standards. The strategy clearly identifies all critical elements of effective records management. This strategy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).
To be read in conjunction with:	191 - Health Records Management Strategy 193 - Retention and Destruction Policy WHC (2000) 71: For the Record. NHS Code of Practice 2009

Owning Committee/ Group	Information Governance Sub Committee. Karen Miles Director of Planning, Performance & Commissioning.

HYWEL DDA UNIVERSITY HEALTH BOARD

Executive Director:	Joe Teape	Job Title	Deputy Chief Executive & Director of Operations

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	
2	Revised	25/8/2015
3	Full Review and DPA update changes	26.6.2018

Glossary of terms

Term	Definition

Keywords	Retention and Destruction

HYWEL DDA UNIVERSITY HEALTH BOARD

CONTENTS

1. INTRODUCTION

This document addresses the principles and practice for managing health records within Hywel Dda University Health Board. The organisation uses a hybrid of computer and paper records to support patient processes and patient care. This strategy establishes how all patient records will be managed and replaces and supersedes any previous health records management strategies that existed in previous organisation formats.

Health records management falls within the remit of the Health Records service. The aim of the health records service is to ensure that procedures are in place to bring together the health professional and accurate, relevant patient information/documentation at the correct time and place to support patient care. The service comprises of 6 main elements:

- control and maintenance of patient appointment systems;
- initiation, retention, security and confidentiality of patients' records;
- registration and recording of all patient encounters;
- compilation, validation and submission of key administrative/demographic data regarding each patient attendance
- provision of an administrative service to respond to medico-legal and data requests made under the relevant "Acts";
- provision of clerical, administrative and reception services to support clinicians and nurses in the delivery of clinical care.

Records management is a key component of the health records service and an expert professional field. The correct creation, management and maintenance of the health record provides the communication tool between the health professional and the patient.

The strategy details the aims, aspirations and targets of what we aim to achieve with our health records management programmes. It provides direction for what we want to achieve within the organisation and also defines what resources are required in future to deliver effective records management programmes.

2. POLICY STATEMENT

Records management is the field of management responsible for the efficient and systematic control of the creation, storage, retrieval, maintenance, use and disposal of health records, including processes for capturing and maintaining evidence.

Proper management of information and a strong records management programme requires adequate resources: sufficient funding, facilities, technologies and knowledgeable experienced people. Consideration of health records management principles requires timely inclusion into service objectives, plans and developments to ensure appropriate resource allocation and implementation of good practice.

The strategy is based on the current requirements of the Welsh Health Circular (WHC) (2000) 71: For the Record. This document covers management of all types of NHS health records throughout their lifecycle, from their creation and use, to their final disposal. The requirement for GP records within NHS Wales are set out in WHC (99) 7: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients. The revised edition of the Department of Health Record Management Code of Practice has not been formally adopted in Wales however, it provides an indicative guide in respect of records that are not detailed in the Welsh Health Circular.

This strategy also takes into account the recommendations and standards set by:

- Public Records Act 1958;
- Medical Reports Act 1988;
- The Computer Misuse Act 1990;
- Access to Health Records Act 1990;
- Data Protection Act, General Data Protection Regulation 2016 or any subsequent legislation to the same effect
- Human Rights Act 2000;
- Freedom of Information (non statutory code S.46 Code of Practice on Records and Information Management)
- Healthcare Inspectorate Wales
- Welsh Assembly Government (Ministerial Letters, Circulars and Policies);
- Standards for Health Services Wales – Standard 20 Records Management
- Patient Records and Information Management Accreditation Programme (PRIMAP);
- Caldicott: Principles into Practice;
- Information Sharing Protocols - Wales Accord on the Sharing of Personal Information
- Data accreditation and data quality
- Information Security assurance - ISO 27001/2 Information security management (formerly BS7799)

This strategy relates to all clinical operational records held in any format by the Health Board. Within the strategy the terms 'Health Record', 'Patient Record' and 'Case record' are synonymous and include:

- records created and maintained by all health care professionals
- records for all specialties
- records for private patients treated on NHS premises

Health Records may be held in many formats, for example:

- paper records, reports, diaries and registers etc;
- electronic records;
- x-rays and other images;
- microform or film (i.e. microfiche and microfilm);
- audio and video tapes
- digital records

The strategy will be updated as required to include future developments such as updated health records management guidance, to reflect technological changes such as the introduction of scanning services and the possible migration to an electronic patient record or changes in legislation.

The Health Records Management Strategy should be read in conjunction with the Health Records Management Policy and supported by the Retention and Destruction of Records Policy.

3. SCOPE

This strategy was written to provide professional advice and guidance for Hywel Dda University Health Board to ensure compliance with all legal requirements for the maintenance, storage and provision and security of records. Identifying key individuals within the Health Board and their obligation to ensure records are managed in accordance and legal requirement and both national and local standards. The strategy clearly identifies all critical

elements of effective records management. This strategy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

4. AIMS

The aim of the Health Board's Health Records Management Strategy is to ensure:

- a systematic and planned approach to health records management covering health records from creation to disposal;
- efficiency and best value for money through improvements in the quality and flow of information, and greater co-ordination of health records and storage systems;
- compliance and delivery with statutory and legislative requirements;
- awareness of the importance of health records management and the need for responsibility and accountability at all levels;
- appropriate archiving of non current health records.
- improve data quality to ensure accuracy and consistency.
- provide assurance around governance, confidentiality, data protection and GDPR.

5. OBJECTIVES

The key benefits and drivers associated with the Strategy is improved Patient Safety and Quality of Care with the deliverable objectives being :

- the improved maintenance of the history of patient care and better communication and information sharing between care providers and patients
- greater efficiencies from the improved management of clinical functions
- reduced duplication of effort
- greater accountability and corporate governance
- reduction in litigation costs through improved patient safety and ability to defend against claims
- compliance with legislation and best practice record standards.

6. KEY ELEMENTS

The Health Records Management Strategy comprises the following key elements:

6.1. Responsibility and Accountability

The Chief Executive has overall accountability for ensuring that Health Records management operates appropriately and in compliance with the requisite legislation within the Health Board. The Chief Executive may delegate responsibility for management and organisation of health records services to a designated Executive/Caldicott Guardian who is responsible for ensuring appropriate mechanisms are in place to support service delivery and continuity.

The Health Records Manager has strategic and operational accountability for the creation, retrieval, storage, archiving and disposal of all health records within the Health Board. The Health Board has in place a documented Health Records Management Policy and detailed documented procedures, to support the life span of a health record from creation to disposal.

6.2. Quality

The Health Records Management Strategy aims to provide assurance that policies and procedures are in place to ensure that the patient and health professional, together with accurate, relevant, reliable patient information and documentation are available at the correct time and place to support effective and safe patient care. The Health Records Management Policy and appendix of policies and procedures provide further detail specifically on standards

for the management of health records. Health records are managed in accordance with the recommendations and standards detailed in the introduction of this strategy.

6.3. Management

All health records are subject to the standards and legislation detailed in the introduction of this document and the Health Board is responsible for ensuring that health records are managed accordingly. The Health Records Management Policy details procedures for the storage, retrieval, archiving and disposal of each record type. This procedure is in accordance with the minimum retention periods detailed in the Welsh Health Circular (2000) 71: For the Record. The Health Board is responsible for ensuring that adequate resources are made available to support effective records management, including making adequate provision for records growth and technological developments which enable records to be stored or transferred to other media. Investment in the move from paper to electronic records will become critical and will support improved patient care and service delivery not only within the Health Records service but across the entire Health Board.

6.4. Security

The Health Board provides systems which maintain appropriate confidentiality, security and integrity for all health records including their storage and use.

Health records in any format are highly confidential documents and the Health Board is responsible for ensuring that adequate physical controls are put in place to ensure the security and confidentiality of all patient identifiable information, whether they are held manually (physically) or on computer (electronically). Other relevant policies and procedures are documented, including the Health Board's Information Security Policy and should be utilised in conjunction with local departmental procedures.

6.5. Access

Access to all patient identifiable information is on a strict need to know basis in accordance with the Caldicott principles, Data Protection, General Data Protection Regulation 2016 or any subsequent legislation to the same effect, Information Governance Standards and various codes of professional conduct. The Health Records Policies, including the Access to Health Records Policy and supporting procedures governing access to patient identifiable information all comply with and are in accordance with these principles.

6.6. Legislation

Health records and associated clinical information are released to patients, their representatives and legal bodies in accordance with relevant and current legislation. The Health Records Manager is responsible for the processing and release of clinical information in accordance with the Access to Health Records Policy and documented procedures.

6.7. Risk Management and Patient Safety

Systems, policies, procedures and processes are in place to ensure that any risks to the record or the patient as a result of record issues, are identified, assessed and managed according to best practice.

6.8. Audit

This Health Records Management Strategy will be audited on a bi-annual basis for compliance against the aims, objectives and responsibilities outlined within the Health Records Management Policy. Full data quality audits fully implemented across the Health Board provide assurance and accuracy and act as an intensive learning tool.

6.9. **Training**

As the volume and complexity of clinical information increases, we demand the highest standards of performance in the way it is gathered, recorded, stored and transmitted. These requirements are set out in the Introduction of this strategy.

In implementing the strategy, the Health Board will put in place training and guidance on legal and ethical responsibilities for all NHS staff involved with the creation, maintenance and ongoing management of health records.

In addition to complying with legislation, training will follow Nationally recognised material and will also use appropriate referenced publications.

Ongoing workforce education plays a major part in preparing NHS staff to deliver effective, high quality services. There are numerous reasons for providing education and training in information handling, including maintenance and improvement of services, respect to patients as well as the need to comply with legislation in respect of data collection, storage and use.

NHS Wales Informatics Service (NWIS) and in particular the Health Informatics Professional Development Programme, are responsible for ensuring health informatics staff in NHS Wales are equipped with the knowledge and skills to rise to the challenges of change and modernisation. The Information Governance e-learning Toolkit has been designed to provide the Hywel Dda Health Board with the tools for effective management of healthcare information. The package covers a range of key topics including Data Protection, GDPR, Information Security, Confidentiality, Caldicott and Disclosing and Sharing of Information which applies directly to health records staff and forms the minimum competency level that staff should reach.

6.10. **Development Programme**

All Health Records Managers or those with a particular responsibility for the administration and management of health records will be able to access appropriate information and guidance concerning record keeping standards. Whenever possible, national standards such as Standards for Health Services Wales – Standard 20 Records Management will be employed to manage all health records throughout the Health Board. In addition to the Standards for Health Service in Wales, the Health Board has added further guidance and support by adopting the IG Toolkit, an audit system currently utilised by NHS organisations in England but adds extra assurance for the management of health records within Hywel Dda. A rolling programme of audit and agreed performance indicators is in operation to enable assessment of individual records system against these standards.

6.11. **Improvement Plan**

A documented health records management improvement plan that identifies prioritised activity to support the implementation of the Health Records Management Strategy will be developed yearly and in conjunction with the Health Records Management Policy. This improvement plan identifies resources (human, financial and organisational) required to ensure that all NHS health records of all types are properly controlled, readily accessible and available for use when required and then eventually archived or disposed of in an appropriate way, regardless of the media on which they are held.

7. NATIONAL STRATEGIC DIRECTION:

'Designed for Life' establishes requirements for:

7.1. 'Fast, safe and effective services:

we will get supply and demand into balance, so that

- for both staff and patients, there is a system they can rely on
- demand is better managed, both at primary and secondary care level,
- freeing up capacity to ensure patients and clients are treated in the right
- place at the right time by the right people
- services are there, when and where they are needed, and meet the
- highest standards of safety and quality.
- skilled staff who provide services that work every time, but are still
- personal to the individual.
- make available accurate, accessible information, backed by high quality
- services
- see that professionals are trained well and have the right information on
- which to base decisions with users
- Electronic records will make care faster and safer and allow people to monitor
- the quality of their own care.'

7.2. Improving Health in Wales: A Plan for the NHS with its partners

(National Assembly for Wales 2001), identified a need for a strategic approach to workforce issues, sustained by partnership working and joint ownership. NLIAH is a national, strategic resource for NHS Wales, designed to assist the service in accelerating the delivery of world-class health services for the people of Wales. It does this by:

- Searching, sourcing, testing and customising the best in the world to
- speed up service transformation
- Growing leadership talent to deliver the service transformation agenda
- Majoring on innovation and the optimum use of technology.
- The NHS Wales workforce is the key to delivering the vision of world class services. Therefore, it is essential that we ensure there are enough staff with the appropriate skills and training in the right place to deliver the best possible service.

7.3. 'Making the Connections'

describes a corporate all-Wales approach to achieving high quality services and efficiency through exploiting economies of scale, throughout the public sector. It defines the operational principles for Informing Healthcare and defines the way in which new information services will be delivered to support patient care. The Electronic Health Record is an electronic and structured set of health information based around an individual's health and care status and encounters across all healthcare sectors and settings.

Currently health records are mainly maintained as paper based documents, however with the progression of various projects within NWIS and Informing Healthcare and electronic solutions, the service is increasingly moving to a hybrid model of paper based and electronic records both active and passive. Health records staff are critical to the successful delivery of these goals. The challenge of moving from manual, to the vision of electronic integrated care records built on modern technology will require the application of skills and experience of health records practitioners and personnel.

"The single patient record is a holistic patient record that is accessible to those who require the information including patients and carers. Currently professional staff in many settings hold fragments of the record, but none have access to the whole record".

The key elements of the plan for a single patient record endorses the move to one patient - one record jointly managed by patients and professional NHS staff with in-built security of access governed by patient consent. Reliable and consistent authentication of patient demographic information is vital when assembling different "fragments" into the same record. The Master Patient Index (MPI) number will be the unique patient identifier, which will unite patients' records irrespective of where they have been created. Whilst departments currently have a plethora of different hospital numbers which are used to identify manual patient records, the relevance of these will diminish to that of a case record filing number as the MPI becomes established throughout all healthcare settings.

8. IMPLEMENTATION

As identified within the Documentation Implementation Plan on page 3 of the Health Records Managment Strategy, dissemination will be lead by the Health Records Committee and all other policy review and ratification groups and to all staff via Team Brief's, the Health Board's policies and procedures web page and via induction and staff training.

9. REVIEW

This strategy will be reviewed every three years (or sooner if new legislation, codes of practice or national standards are to be introduced).