WITN4196007

THIS IS THE EXHIBIT marked CB6 referred to in the Statement of Dr Christopher Bunch dated 24 September 2019.

Health Records Management Policy

Category:	Policy
Summary:	The Trust has a legal obligation to ensure that records are maintained on all patients that receive care within the Trust. This policy and supporting procedural document defines the user's responsibilities for handling health records folders and libraries across the Trust.
Equality Impact Assessment undertaken:	May 2015
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Author(s):	Health Records Service Manager
Further Information:	Health Records Service Manager
This Document replaces:	Health Records Management Policy V5.0

Lead Director: Director of Planning & Information

Issue Date: 18 June 2015

Contents

Health Records Management Policy

Introduction

1. The use of records and patient's access to them is governed by the Data Protection Act 1998 and the Access to Health Records Act 1990.
2. The Trust has a legal obligation to ensure that records are maintained on all patients that receive care within the Trust.
3. Health records are created to ensure that information is available within the Trust:
   - 3.1. to support delivery of high quality evidence based care
   - 3.2. to meet legal requirements
   - 3.3. to assist clinical and other audits
   - 3.4. to support archival functions by taking account of the historical importance of material and the needs of future research
4. This policy and supporting procedural document defines the users' responsibilities for handling health records folders and libraries across the Trust.

Policy statement

5. All staff that in the course of their duties uses the health record must act to promote the procedures within the policy and procedure guidelines in relation to the correct format and filing of paperwork within the health records folder.
6. Staff utilising the health records folders and libraries throughout the Trust are required to follow the process guidelines contained within the Health Records Procedure to ensure that:
   - 6.1. The filing procedure is maintained and that alerts and sensitivities are recorded correctly
   - 6.2. That written records are complete (in a timely manner), accurate and identifiable to the patient
   - 6.3. Users are aware of their responsibilities in relation to the health records folder
   - 6.4. Users are aware of their responsibilities in relation to records requests and processes within the Trust libraries, including creating, tracking, retrieval and retention of records

Scope

7. A health record refers to any record that has a service user's name on it. This therefore includes all medical, nursing and allied health professional records made by any member of Trust staff.
8. All staff employed by the Trust are required to ensure confidentiality, integrity, accuracy and appropriate availability of health records whether held manually or electronically.

Aim

9. This policy aims to set out the Trust's approach to health records management, making explicit the importance of record keeping as an integral part of the care of service users.

10. The purpose of this policy is to:

    10.1. Enable the Trust to conduct its business in the most efficient and effective way.

    10.2. Promote effective and chronological monitoring of clinical care with high quality systems for clinical record keeping and collection of relevant information in line with clinical governance.

    10.3. Promote better communication and dissemination of information between members of the inter-professional health care team.

    10.4. Provide good quality patient records which are essential to the effective care of patients and which detail reasons for effective decisions, interventions and risks to patients whilst adequately reflecting the care given.

Definitions

11. In the context of this policy a **health record** is anything that contains information (in any media) that has been created or gathered as a result of any aspect of the work of the NHS employees. Health records are also known as:

    11.1. medical records

    11.2. case note folders

    11.3. case notes

12. What constitutes a health record?

    The following items would be counted as a record:

    12.1 handwritten notes produced by a health care professional

    12.2 computer printouts from monitoring equipment

    12.3 laboratory reports

    12.4 photographs

    12.5 x-rays

    12.6 correspondence relating to clinical information, including handwritten or computer produced referral letters.

Responsibilities

13. The **Chief Executive** has overall responsibility for records management within the Trust.

14. The **Director of Planning and Information** has delegated authority for information management, technology and the health records management function.

15. The **Senior Information Risk Officer/Director of Planning and Information** is responsible for putting in place procedures to ensure compliance with this policy.

16. **Divisional Directors and Clinical Directors** are responsible for ensuring that their staff are made aware of and are complying with this policy and procedure guidelines.

17. **Health Records Service Manager** is responsible for the records management function across the Trust and for the retention, disposal and destruction of records.

18. The **Subject Access Team** are responsible for releasing patient record information in relation to personal access requests.

19. The **Data Protection Officer** is the Information Protection Officer for the Trust, with additional duties providing Information Governance support and training.

20. **Health Records Library Managers** support the Health Records Service Manager with responsibilities for the records management function across the Trust.

21. **All staff** have a responsibility to ensure that they are aware of and implement the policy and the procedures that are relevant to their area of work.

Legal obligations that apply to records

22. The use of records and access by patients to them is governed by the Data Protection Act 1998, the Access to Health Records Act 1990 and NHS Code of Practice: Records Management Part 1&2 2006.

23. NHS employees are responsible for records that they create; any records created by an NHS employee are public records and may be subject to both legal and professional obligations.

24. The transfer and disclosure of health records are governed by a number of statutory provisions that set conditions on their disclosure. The Access to Health Records Act 1990 and the Data Protection Act 1998 makes specific reference to the disclosure of the patient's health record. Guidance on these requests can be obtained from the Subject Access Team, the Data Protection Officer for the Trust and from the Trust's Legal Department.

25. For further information on Subject Access Requests contact the Subject Access Supervisor on ext 34855.

Clinical standards for documentation and record keeping

26. Clinical records provide the main channel of clear and comprehensive communication between all members of the clinical team caring for any patient. Only by recording the detail of all assessments, interventions and outcomes can it be assured that any individual clinician may safely rely on those records in making a fully informed decision about treatment and care.

27. All professional staff are accountable for their practice and in the exercise of their professional accountability must act to promote and safeguard the interest and well-being of the patients and ensure that no action or omission is detrimental to the interests or safety of the patients.

28. All professional staff will comply with the documentation recommendations set down by their professional and regulatory bodies.

29. Full details on the standards for documentation can be found in the Health Records Procedure, but a summary is listed as follows.

    29.1. All entries must be legible.

    29.2. All entries to be written in blue or black ink (pharmacist may use alternative)

    29.3. Each page to include the name and hospital number of the patient.

    29.4. All results and reports correctly filed.

    29.5. All entries must be timed, dated, signed, attributable to the author, including job role

    29.6. Records must be complete and accurate such that clinical colleagues can make critical judgements with the benefit of all the relevant information. Detailed observation of the facts must be recorded precisely and objectively. This is especially important in the context of arrangements for handover.

29.7. Any errors or anomalies that are identified when using the health record should be brought to the attention of the consultant responsible for the patient and an incident form must be completed.

30. A clinical audit will be undertaken every 18 months across clinical services to assess adherence to these standards. The template for reporting this audit can be found at Appendix 1.

How to track health records

31. Accurate recording and control of the location of all records is crucial if the information they contain is to be located quickly and effectively. All staff have a responsibility for the accurate and safe movement of health records folders in and around the Trust. Staff are to ensure that:

31.1. Records are tracked at each stage of their movement using the HIM Tracking Application within the Millennium System.

31.2. Records are stored securely on wards and departments with clear labelling on shelves/cupboards/filing cabinets.

31.3. Records are returned to their original filing system after use.

32. Wards, departments, secretariats and clinical areas are designated location codes that allow users of the HIM Tracking Application within Millennium to track records to the location area. On creation of the paper record the tracking audit trail should commence. Location codes should be updated every time the health record moves to a different location.

33. Additional media type and volume numbers must be added to the patients details within the HIM Tracking Application at the point of creation.

34. Temporary folders may be created when all efforts have been made to source the patient's substantive health record. These should be created within HIM Tracking Application as a temporary file. When health records cannot be found in the location to which they are tracked , this must be reported to the Senior Library Manager by completing HRSD1 which can be found in the Health Records Procedure.

35. Some specialities such as Oncology and ENT have health records which are separate to the standard Trust health record. Therefore care must be taken to ensure users of Millennium track the correct set of health records for a patient.

36. For further information please refer to the Trust's *Health Records Procedure.*

How a new record is created

37. A health record can be created once a patient has a unique hospital number assigned by the Millennium System. Both administrative and clinical staffs are responsible for the creation of Medical Records Numbers within the OUH Trust.

38. A search should be performed within the Millennium System to ensure the patient does not already have a health record from the Trust. If not, then one is created by labelling a blank health records folder with the patient's details. This should include the patients name and medical records number as minimum. Where part of the record is also held electronically a yellow sticker should be placed on paper record to indicate that there are electronic records held on the Millennium System. The existence and location of the health record should then be logged within the HIM Tracking Application in Millennium so that the file can ve tracked throughout current and future patient episodes of care. For further information please refer to the *Health Records Procedure.*

How to retrieve health records

39. The central medical libraries provide 24 hour cover for access to current health records. Electronic tracking systems control the movement of all patient records to enable:

    39.1. records to be located and retrieved when required;

    39.2. prevent loss of records;

    39.3. maintain an audible trail of records transactions.

40. In order to maintain the security of records, only authorised staffs that have attended appropriate health records training modules are allowed access into health records libraries. This access is controlled by swipe card. For training please refer to *Health Records Procedure*.

41. Authorised personnel may visit the library to retrieve and track the records required. Records may also be retrieved from libraries by Health Records Department staff for scheduled clinics and emergency patient admissions.

42. Records that are stored outside of records libraries are requested from the ward or department that they are tracked to, by phone, fax or email. It is the responsibility of the person or department that holds the records to arrange delivery to the area that requires them.

43. The methods used to move records about the Trust are by hand delivery, by internal post or by shuttle bus. For further information on retrieving health records for clinic preparation purposes or when notes are not located within the libraries, please refer to the *Health Records Procedure*

Retention, disposal and destruction of health records

Retention

44. Historically the Trust has not destroyed records; rather it has retained all records permanently. This process is currently under review.

45. The schedule for the retention and destruction of records within the ORH Trust is based on guidance issued in the Department of Health's Records Management: NHS Code of Practice. Appendix 5 of the Health Records Procedure summarises the national guidance.

46. Authority and decision making on the phased culling schedule of health records throughout the Trust will be through the Information Governance & Data Quality Group. The resulting schedule will be implemented by the Health Records Service Manager

47. Health Records that require permanent preservation e.g. for research purposes are identified by the Health Records Services Manager using the alert notification on the front cover of the case note folder noting that the folder is NOT FOR DESTRUCTION BY ORDER OF THE HEALTH RECORDS SERVICE MANAGER.

Disposal

48. The OUH has adopted a culling process relating to patient's who have not attended the Trust in the previous six months. These records are then moved to an off-site storage location.

49. Off-site storage is organised by the Health Records Services Manager. The Trust uses Restore Ltd, located at 234, Heyford Park, Upper Heyford, Oxfordshire OX25 5HA. They are on the NHS list of accredited suppliers of storage services and comply with relevant guidance. The requirement to comply with relevant national guidance is part of the terms and conditions of the contract with the supplier.

50. All library staff are trained on the culling process before they are allowed to proceed with this work.

51. Culling process includes:

    51.1. identification of correct patient on Millennium and paper record

    51.2. last date of attendance

    51.3. future appointment dates

    51.4. tracking of record to off-site storage company

    51.5. correct boxing of records for collection by off-site storage company

52. All notes are bar-coded and stored against a Restore registration number which can be cross-referenced against the OUH number.

53. These arrangements are audited once a year by the Trust's internal auditors.

54. For information on how to request records stored at Restore back to the ORH site refer to *Health Records Procedure.*

Destruction of records

55. Where the Trust destroys records in line with the retention of records guidance it employs an accredited external supplier.

56. The Trust's currently preferred company to undertake the physical destruction of the paper record is: Greenstar, (Leicester paper Processors) Ltd. On completion of any destruction of records the Trust is supplied with a 'Certificate of Destruction.'

57. The Health Records Service Manager for the Trust is responsible for making all arrangements in relation to this work.

58. All library staff are trained on the destruction process before they are allowed to proceed through any agreed destruction schedule.

59. Notes acknowledged for destruction are:

    59.1. identified on Millennium tracking module for permanent preservation as destroyed against patient's hospital number

    59.2. notes are stored in secured area for collection by accredited company

    59.3. the accredited company will then remove the records for destruction.

    59.4. Certificate of Destruction is supplied to Trust on destruction completion

Training

60. Health record keeping is a professional responsibility for all staff. As such specific record keeping training is not mandated by the Trust. However ad-hoc training is provided at a local level when a specific need for it is identified. These training needs may be identified through a range of methods including records audits, investigations of incidents/complaints/claims, personal development plans and appraisals.

61. Where appropriate, training on standards of record keeping may be delivered by the Risk Management Advisors or Legal Services Advisors. High risk areas such as maternity include documentation training as part of their annual updates for staff.

62. The Health Records Library Services supports, and provides training on health records and library procedures, particularly in relation to the creation, tracking, confidentiality and

pulling of files within library areas. This training is considered 'essential' for all staffs that in the course of their duties uses the patient's health records file and it is included in the induction package for all new starters to Trust. For further information, contact Health Records Training on ext. 72414.

63. With regard to electronic patient records, staff are not authorised to access the system until they have received appropriate training. This training is provided by OUH IM&T. Staffs are not provided with a 'log-in' until training is completed. For further information, contact OHIS training on ext. 22822

Monitoring Compliance

64. Compliance with the document will be monitored in the following ways:

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Duties	*To be addressed by the monitoring activities below.*			
Legal obligations that apply to records	Internal Audit: PAREC database	Subject Access Supervisor	Annually	Information Governance & Data Quality Group
Process for tracking records	Internal Audit OXPAS Tracking Module	Senior Library Manager	Annually	Information Governance & Data Quality Group
Process for creating records	Internal Audit Form: NONOTES	Senior Library Manager	Annually	Information Governance & Data Quality Group
Process for retrieving records	Internal Audit Form: RETCHECK	Senior Library Manager	Annually	Information Governance & Data Quality Group
Process for Records Retention/disposal and destruction	HRRS2 Phasing, Health Records Services	Health Records Service Manager	Statistics/scheduling	Information Governance & Data Quality Group
Basic record keeping standards	Clinical Audit (Sample of areas throughout Trust)	Clinical Audit Department	Every 18 months	Clinical Risk Management Committee
Process for ensuring a contemporaneous complete record of care	Clinical Audit (Sample of areas throughout Trust)	Clinical Audit Department	Every 18 months	Clinical Risk Management Committee
Staff training	This is not formally monitored as it is ad hoc training.			

Review

65. This policy will be reviewed in 3 years, or sooner if national guidance or local arrangements require.

References

66. Data Protection Act 1998
67. Access to Health Records Act 1990
68. NHS Code of Practice: Records Management Part 1&2 2006
69. Information Governance Toolkit

Equality Impact Assessment

70. As part of its development, this policy and its impact on equality has been reviewed The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. No detriment was identified. (See appendix 1)

Document History

Date of revision	Version number	Reason for review or update
June 2012	V4.0	Changes to reflect OUH Trust Inclusion of Millennium Electronic Patient Record system
May 2013	V5.0	Correction of review date
May 2015	V6.0	Change to records retrieval information Update to retention & disposal information Revision of training information Correction in monitoring compliance information

Appendix 1-Equality Impact Assessment

Equality Analysis
Policy / Plan / proposal name: Health Records Policy
Date of Policy June 2015
Date due for review June 2018
Lead person for policy and equality analysis Health Records Service Manager
Does the policy /proposal relate to people? If yes please complete the whole form. YES
The only policies and proposals not relevant to equality considerations are those not involving people at all. (E.g Equipment such as fridge temperature)
1. Identify the main aim and objectives and intended outcomes of the policy. Who will benefit from the policy? How is the policy likely to affect the promotion of equality and minimize discrimination considering: age, disability, sex/gender, gender re-assignment, race, religion or belief, sexual orientation, pregnancy and maternity, marriage or civil partnerships or human rights? The aim of this Policy is to : • ensure all staff understand their responsibilities regarding the creation and completion of patient health records • to improve the patient care pathway in relation to correct record keeping • to promote understanding of compliance to legal requirements in relation to patient records
2. Involvement of stakeholders. List who has been involved in the policy/proposal development? Health Records Service Manager Caldicott Guardian
3. Evidence. Population information on www.healthprofiles.info search for Oxfordshire.
Disability Have you consulted with people who has a physical or sensory impairment? How will this policy affect people who have a disability? No potential to discriminate has been identified Copies of the Policy can be provided in different formats.
Disability: learning disability

Sex How will the policy affect people of different gender? No effect.
Age: How will the policy affect people of different ages – the young and very old? Not applicable
Race: How will the policy affect people who have different racial heritage? Not applicable
Sexual orientation: How will the policy affect people of different sexual orientation- gay, straight, lesbian, bi-sexual? Not applicable
Pregnancy and maternity: How will the policy affect people who are pregnant or with maternity rights? Not applicable
Religion or belief. How will the policy affect people of different religions or belief – or no faith? Not applicable
Gender re-assignment. How will the policy affect people who are going through transition or have transitioned? Not applicable
Marriage or civil partnerships: How will the policy affect people of different marital or partnership status? Not applicable
Carers Remember to ensure carers are fully involved, informed, supported and they can express their concerns. Consider the need for flexible working. How will carers be affected by the policy? Not applicable
Safeguarding people who are vulnerable: How has this policy plan or proposal ensured that the organisation is safeguarding vulnerable people? (E.g. by providing communication aids or assistance in any other way.) Not applicable
Other potential impacts e.g. culture, human rights, socio economic e.g. homeless people Not applicable
Section 4 Summary of Analysis Does the evidence show any potential to discriminate? If your answer is no – you need to give the evidence for this decision. No , all patients will be treated equally
How does the policy **advance equality of opportunity?**
How does the policy **promote good relations between groups?** (Promoting understanding) Will enhance the care of patients by ensuring good record keeping standards are upheld

Appendix 2: Clinical Audit Report Template and Action Plan

Insert audit title
Insert date

EXECUTIVE SUMMARY
This is usually written last and condensed using the headings from the report.
Introduction
Use it to explain the reasoning behind undertaking the audit. The introduction should highlight: • when the audit was undertaken • how many people/items were audited • why the need for audit was identified • an outline of the aims and objectives of the audit • standards/best practice guidelines used to audit against A review of any previous work undertaken should also be included here.
Methods and Sample
Briefly explain the method used and how the sample was chosen. It should include enough detail to allow anyone re-auditing to use the same approach and methodology. • who was involved • what type of data collection tool or scale was used • any difficulties that were experienced • timescale • any expectations
Results
This section should include results only, without bias – do not comment on findings here. Where possible, outline your findings using visual aids such as tables or charts. All tables and figures should have a title and be understood without reference to the text. • Highlight areas of success • Highlight problem areas Data presentation should be consistent – e.g. decimal places, percentages.
Discussion
Do not introduce new data Draw on the results and make careful interpretation of the findings Compare the results to other audits Discuss the strengths and weaknesses of the audit – any discrepancies Discuss the meaning of your findings and possible implications for practitioners
Conclusion
State key findings and their implications Put forward recommendations for change Suggest areas for further works and plans for re-audit if appropriate

Recommendations
Identify areas for improvement. Possible suggestions (i.e. better documentation, training requirements, change of practice) Reference* (where appropriate) *If you have read around your audit subject you should include references of the literature read in this report
Action Plan
You have invested time in completing your audit but it does not end there. The action plan is a fundamental part of the audit, without it the audit is not effective and you have just wasted time, money and effort. By developing and implementing the action plan you will have completed the audit loop. • Complete the action plan template • Bullet points are best, short and snappy • Assign a named person per action if possible Plan a date for a re-audit
Author of report (including job title) and date

Appendix 2 (continued): Clinical Audit Action Plan

Problem identified		Cause (s) of problem	Action to be taken	Who to complete	Date to complete by	Date completed
1						
2						
3						
4						
5						