University Hospitals Coventry and Warwickshire NHS Trust

Title of Trust-wide CBR:	
Health Records Operational Management Policy	
eLibrary ID Reference No:	*GOV-POL-014-08*
Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following Trust approval. Reviewed Trust-wide CBRs must retain the original eLibrary reference number. *The Quality department will progress all new, re-written and reviewed CBRs for final Trust approval.*	
Version:	10.0
Title of Approving Committee	Information Governance Committee
Date Approved by Approving Committee:	
Risk Rate: *(this must be applied by the Author prior to being submitted to the Quality Dept. (refer to CBR guidance pack))*	Medium
Next Review Date: *(dependant on risk rating or sooner if deemed necessary – refer to CBR guidance)*	1st March 2018
If printed, copied or otherwise transferred from eLibrary, Trust-wide Corporate Business Records will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version which is registered on eLibrary. ***As a controlled Trust-wide CBR, this record should not be saved onto local or network drives but should always be accessed from eLibrary.***	

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	The Trust is committed to a systematic and planned approach to the management of Health Records (both paper and electronic)
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To set out the approach to be taken within the Trust to provide a system for the management of Health Records (both paper and electronic)
Trust-wide CBR to be read in conjunction with: *(List overarching/underpinning strategies, policies and procedures – refer to CBR Evidence Summary)*	Records Management Strategy v7.0 Standards for Content of Health Records v6.0
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Governance
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please complete the 'Request for Removal of CBR' form and submit to Quality Dept – please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	Health Records Management Policy v9.0

Author's Name, Title and email address: *(must not be the same as reviewer)*	Jan Ayscough, Operational Governance and System Standards Manager
Reviewer's Name, Title & email address: *(must not be the same as author)*	Dr A Price-Forbes Consultant Rheumatologist and Lead for EPR Programme
Chief Officer's Name, Title:	Karen Martin Chief Workforce and Information Officer
Title of Group/Department/Specialty:	Health Records

Version	**Consulting & Endorsing Stakeholders, Committees/Meetings/Forums etc** *List **all** Approving, Consulting & Endorsing Stakeholders for this version of the CBR, and include direct consultation with named individuals, Committees/Forums/Bodies/Groups, refer to guidance pack.*	**Date**
10.0	Health Records Committee	March 2017
10.0	Information Governance Committee	May 2017

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1.0 SCOPE

1.1 This policy relates to all health records held in any format by the Trust. These include:

- All patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers etc).

1.2 This policy relates to all Trust staff who use/handle health records (both paper and electronic).

2.0 INTRODUCTION

2.1 Records Management is the process by which an organisation manages all the aspects of health records, whether internally or externally generated and in any format or media type, from their creation, all the way through their lifecycle to their eventual disposal.

2.2 The Records Management: NHS Code of Practice has been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice, (Freedom of Information Act 2000, the Environmental Information Regulations 1994 and the Data Protection Act 1998). All records must be kept and maintained in accordance with statutory requirements and NHS Guidelines.
The Trust's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support

consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways.

2.3 The Trust Board has adopted this records management policy and is committed to ongoing improvement of its records management functions as it believes that it will gain a number of organisational benefits from so doing. These include:

- quality improvement and patient safety;
- better use of physical and server space;
- better use of staff time;
- improved control of valuable information resources;
- compliance with legislation and standards;
- reduced costs and improved data quality

2.4 The Trust also believes that its internal management processes will be improved by the greater availability of information which will accrue by the recognition of records management as a designated corporate function.

2.5 This document sets out a framework within which the staff responsible for managing the Trust's health records can develop specific policies and procedures to ensure that health records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

2.6 This policy document should be read in conjunction with the Trust's Records Management Strategy v5.0 which sets out how the policy requirements will be delivered.

3.0 STATEMENT OF INTENT

3.1 The aims of our Records Management System are to ensure that:

- records are available when needed - from which the Trust is able to form a reconstruction of activities or events that have taken place (see Appendix 11 - procedure for retrieving records)

- records can be accessed - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;

- records can be interpreted - the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;

- records can be trusted – the record reliably represents the information that was actually used in, or created by, the clinical process, and its integrity and authenticity can be demonstrated;

- records can be maintained through time – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;

- records are secure - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required (Appendix 4).

- records are retained, disposed of and destroyed appropriately - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value. The Trust's Health Records Management Policy has been up-dated to reflect HSC 291514 (Records Management: NHS Code of Practice –Part 2 – Appendix 13) which extends the retention period for certain types of records (eg blood transfusions administered since 2005 where paperwork is required to be retained for 30 years). Due to difficulties in easily identifying records which will have to be retained for 30 years, it has been agreed to retain all health records for this period. This excludes health record documentation that is not stored within the health record folder (specifically Emergency Department registration and clinical notes sheets: casualty cards if patient not admitted or has no follow up outpatient activity, and wet film x-rays that have reached the NHS Code of Practice Part 2 retention period). This blanket retention period will be reviewed and reduced to

reflect the NHS Code of Practice Part 2 retention periods by continuing to target specific patient groups e.g. deceased males. In order to achieve the 5th principle of the Data Protection Act 1998, operational processes will be put in place that will ensure that all records which fall into the extended retention periods can be easily identified in future, and as new technology is introduced, these will be used to identify those records from this point on. This will ensure that personal data is not kept longer than necessary.

- staff are trained - so that all staff are made aware of their responsibilities for record-keeping and health record management including handover sheets and other patient related paperwork that may be printed for clinical purposes. Any such paperwork must be confidentially destroyed.

4.0 DEFINITIONS

4.1 Records Management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Trust and preserving an appropriate historical record. The key components of records management are:

- record creation;
- record keeping;
- record maintenance (including tracking of record movements);
- access and disclosure;
- closure and transfer;
- appraisal;
- archiving, disposal
- destruction

The term ‘Records Life Cycle’ describes the life of a record from its creation/receipt through the period of its ‘active’ use, then into a period of ‘inactive’ retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation. (Appendices 1, 2, 3 and 12).

4.3 In this policy, Health Records are defined as 'recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity'

4.4 Information is a corporate asset. The Trust's records are important sources of administrative, evidential and historical information. They are vital to the Trust to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

4.5 Health Record Procedures (please see appendices below) have been approved (and will be added to as appropriate) and circulated to local records managers for distribution. These procedures can also be accessed via the Trust e-Library and the Health Records Web site on the Trust intranet.

5.0 DUTIES / RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive has overall responsibility for records management in the Trust. As accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate, accurate information is available as required.

The Trust has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements. These responsibilities apply to the implementation and management of any external contracts for record management services.

5.2 Caldicott Guardian

The Trust's Caldicott Guardians for UHCW NHS Trust are the Chief Medical Officer and the Director of Quality and have particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

Health Records Committee is the forum through which the Trust's strategy for the management of paper records are agreed and assured. It is also responsible for the effectiveness of the management of the health records service throughout the Trust.

5.3 Health Records Manager

The Operational Governance and System Standards Manager is responsible for the overall development and maintenance of health records management practices throughout the Trust, in particular for drawing up guidance for good records management practice and promoting compliance with this policy in such a way as to ensure the easy, appropriate and timely retrieval of patient information.

The Operational Governance and System Standards Manager is also responsible for ensuring that there is effective liaison between the Trust and any external contract for health record services.

5.4 Local Records Managers

The responsibility for local records management is devolved to the relevant directors, Group Managers and department managers. Heads of Departments and other areas/departments within the Trust have overall responsibility for the management of health records generated by their activities, i.e. for ensuring that records controlled within their unit are managed in a way which meets the aims of the Trust's health records management policies.

5.5 All Staff

All Trust and contractor staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. All staff must ensure that they follow health record processes and operational guidance at all times. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and with any guidance subsequently produced. Refer also to the Policy for the 'Standards for the Content of Health Records' available via e-library.

6.0 DETAILS OF THE POLICY

6.1 Procedures underpinning this policy have been written / implemented (appendices 1 – 16), and will be used in conjunction with the processes agreed with the outsourced

health records service provider, to ensure a stable, accurate, measurable health records service, that reduces risks to provide clinical care to patients, by ensuring records are available at the time required (paper and electronic). Refer to the appendices for details of:

- The process for tracking records
- The process for creating records
- The process for retrieving records
- The process for the retention, disposal and destruction of records

6.2 UHCW will implement the scanning of current episode paperwork (day forward), and in time, the physical case notes (legacy records) for specific specialities/long retention diagnosis and conditions. The implementation will take a phased approach starting in 2016 (phase I) with nominated specialties/areas, and will be rolled out to the rest of the Trust in 2016. During phase I for those specialties and areas included, where case notes are currently being delivered, this will continue (if clinically required), but the case notes should be used for reference purposes only in those phase I areas. In all other areas during phase I, case notes should be used as 'normal' with paperwork being added to the latest case note volume.

Paperwork that has been scanned will be available within the Electronic Document Management system (EDM), via CRRS. Any member of staff who has access to CRRS will automatically have access to view scanned images within the EDM.

Refer to the appendices for details of:

- Phase I day forward scanning
- Go live for rest of Trust
- Legacy record scanning

7.0 DISSEMINATION AND IMPLEMENTATION

7.1 When the policy has been appropriately consulted on and Trust approved, it will be registered and uploaded onto the Trust's eLibrary records management system, which is accessible to all staff at all times.

This policy will be implemented and disseminated through a series of awareness sessions available to all staff, and staff will also be made aware of their own personal responsibilities in respect of the business records they create or use in the performance of their duties.

7.2 Awareness will be disseminated at Administration Academy sessions, ward clerk Data Quality workshops, and bespoke sessions available on request to the Trust Health Records Team

8.0 TRAINING

8.1 Trust staff will be made aware of their responsibilities for record-keeping and record management through generic and specific training programmes and guidance – please see Dissemination and Implementation above.
Appropriate training for the EDM will be made available to relevant staff via communications, user guides, e-learning, local champions and peer support.

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

The table below outlines the trusts' monitoring arrangements for this policy / document. The trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

9.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual/ department responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Quality of record tracking	*Use of agreed proforma*	*Each Group Via Group Manager*	*Monthly mini audit/quarterly larger audit*	*Health Records Committee*	*Health Records Committee Clinical Reference Group*
Audit of quality of records ie preparation	Spot checks Of a minimum of 50 records	Trust health records team	Quarterly	Health Records Committee	Health Records Committee
Report of records not located for TCI's	Use of information provided by the records service provider	Trust health records team	Daily	Health Records Committee	Health Records Committee
The policy reflects the legal obligations that apply to records	Review	Trust health records team	Annual	Health Records Committee	Health Records Committee

10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary Procedure is available from eLibrary.

11.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 ETHICAL CONSIDERATIONS

The Trust recognises its obligations to maintain high ethical standards across the organisation and seeks to achieve this by raising awareness of potential or actual ethical issues through the CBR consultation and approval process. Authors of CBRs are therefore encouraged to liaise with the Trust's Clinical Ethics Forum to seek input where necessary.

13.0 REFERENCES AND BIBLIOGRAPHY

13.1 Department of Health, Records Management: NHS Code of Practice (Part 2)
13.2 UHCW Records Management Strategy
13.3 Terms of Reference Health Records Management Committee
13.4 UHCW Standards for the Content of Health Records
13.5 ICT Security Policy

Records Management: NHS Code of Practice Part 1 (Department of Health, 2006, Gateway ref 6295)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133196.pdf

Records Management: NHS Code of Practice Part 2 (Department of Health, 2009, Gateway ref 10678)
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093024.pdf

Confidentiality: NHS Code of Practice (Department of Health, 2003, Gateway ref 2003)
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069254.pdf

14.0 UHCW ASSOCIATED RECORDS

14.1 Standards for the Contents of Health Records Policy v6.0

15.0 APPENDICES

1. Health records Procedure 1: Raising new case note folders
2. Health records Procedure 2: Raising new volumes of case notes
3. Health records Procedure 3: Requesting a replacement case note folder
4. Health records Procedure 4: Tracking of case notes and X-rays
5. Health records Procedure 5: Monitoring the effectiveness of all health records procedures
6. Health Records Procedure 6: Identifying Potential Amalgamations
7. Health Records Procedure 7: Merging of Identified Duplicate Registrations
8. Health records Procedure 8: Transportation and use of records off site
9. Health records Procedure 9: Loose filing in records
10. Health Records Procedure 10: GP Discharge Letters
11. Health Records Procedure 11: Requesting Records
12. Health Records Procedure 12: Retention, Disposal and Destruction
13. Health Records Procedure 13: BMI Processes
14. Health Records Procedure 14: Other External Providers

15. Health Records Procedure 15: Process for Taking Records/Data Off Site
16. Health Records Procedure 16: Process for Implementation of Phase I Day Forward Scanning of Health Records
17. Health Records Procedure 17: Process for Implementation of Day Forward Scanning Rest of Trust
18. Health Records Procedure 18: Process for Scanning of Legacy Records
19. Retention and Destruction HSC 291514 (Records Management: NHS Code of Practice – Part 2)

Appendix 1

HEALTH RECORDS PROCEDURE 1 (v1)

RAISING NEW CASE NOTE FOLDERS

Aim

Any patient attending the Trust for planned activity will be issued with a bar coded case note folder. This should automatically be raised by the Contractor (TNT) for any patients who do not have a current volume. This will apply to any patients attending the Trust for the first time (1/G - iPM), and for patients who have not attended for over 8 years and whose records have been destroyed according to the Trust's previous Retention and Destruction timeframes. (These will become volumes G02 or 2/G +)

In some instances patients attending the Trust for unplanned activity (not normal A&E attendances) will need a new case note. These should be requested from the Contractor (TNT) as follows:

Process

- Completion of an e.form.
- Completion of all mandatory fields, including patient number and name.
- Add "**new case note required"** within the comments field.
- TNT are contracted to respond to your request within 48 hours. If you do not receive your request within this period please email MROS Liaison Team

Please also see appendix 11 below 'Requesting/Delivery of Records' and reference to the 'Survival Guide to Health Records'.

Appendix 2

HEALTH RECORDS PROCEDURE 2 (v1)

RAISING NEW VOLUMES OF CASE NOTES

Aim

New volumes should only be raised if the current folder is too large to hold the documents which need to be contained within it safely (the maximum depth of a folder should be approximately 7 cms); or if the original records have been destroyed according to the Trust's Retention and Destruction policy. The Contractor (TNT) will check all case note folders for size prior to sending into the Trust.

Process

- Check the Patient Administration System to ensure that the subsequent volume does not already exist.
- Completion of an e.form.
- Completion of all mandatory fields, including patient number and name.
- Add "**new volume required, including the volume number"** within the comments field.

Please also see appendix 11 below 'Requesting/Delivery of Records' and reference to the 'Survival Guide to Health Records'.

Appendix 3

HEALTH RECORDS PROCEDURE 3(v1)

REQUESTING A REPLACEMENT CASE NOTE FOLDER

Aim

The Contractor (TNT) will replace any badly damaged or very old folders with inadequate filing binders prior to sending them to the Trust. If you have a damaged folder within your possession a new folder should be requested from the Contractor (TNT) as follows:

Process

- Completion of an e.form.
- Completion of all mandatory fields, including patient number and name.
- Add "**replacement folder required, including the appropriate volume number"** (same as on the folder being replaced) within the comments field.
- TNT are contracted to respond to your request within 48 hours. If you do not receive your request within this period please email the Trust Health Records Team.

Please also see appendix 11 below 'Requesting/Delivery of Records' and reference to the 'Survival Guide to Health Records'.

Appendix 4

HEALTH RECORDS PROCEDURE 6(v2)

TRACKING OF CASE NOTES AND X-RAYS

Aim

To ensure that all Health Records can be easily located at any time and are therefore available for patient care.

Process

- All case note folders and x-ray bags are marked with a unique barcode that reflects the PID and the volume of the health record. (This is undertaken by TNT whenever a new folder is raised)
- It is the responsibility of every user to ensure that each movement of the health record is recorded on the PAS (iPM). (i.e. when a record is received and when it is sent elsewhere or returned to TNT)
- The health record can be tracked on iPM either manually (by keying in the PID and volume details) or by use of a barcode scanner.
- Each user must ensure that the correct location to which the record is being sent, is selected from the appropriate drop down table and that details of the person to whom the records are being sent is typed into the comments field.
- Upon receipt of the records the user must ensure that iPM is up-dated to record that the records have been received.
- The Trust health records team (MROS) is responsible for the monitoring of tracking use, via audits, and locating missing records.
- Records required for TCI's that are not located by TNT will be chased by the Trust health records team, and the data is made available to the Divisional Dashboard for specialty use.

Appendix 5

HEALTH RECORDS PROCEDURE 7(v1)

MONITORING THE EFFECTIVENESS OF ALL HEALTH RECORD PROCEDURES

Aim

To ensure that all Health Records procedures are relevant for the purpose and are followed correctly by users of the Health Record. To ensure that all procedures are reviewed annually or each time processes change within the organisation.

Process

- The Trust health records team is responsible for ensuring that Health Records processes are in place and fit for purpose.
- The Trust health records team will provide advice and support to all users of Health Records routinely and on an ad hoc basis.
- The Trust heal records team, in conjunction with the Trust Data Quality Manager, will review processes and procedures, and produce new processes as and when required, to support service provision.
- The Trust health team will use computerised reports from iPM and O'Neill (TNT) systems to ensure that procedures are being followed.
- The Trust health records team will record any complaints/incidents relating to the Health Record service.
- The Trust health records team will produce ad-hoc reports and recommendations for the HRMC (based on above).

Appendix 6

HEALTH RECORDS PROCEDURE 4(v1)

IDENTIFYING POTENTIAL AMALGAMATIONS

Aim

Any patient attending the Trust should be easily identifiable from a unique patient registration number on the Master Patient Index. This number should also be used on the patient's health record, and the details recorded on the MPI should reflect the information contained within the health record and any subsequent documentation raised. In the course of the patient's activity within the Trust it may become apparent that the patient has more than one patient registration and/or more than one set of case notes.

Process

- Acquire as much demographic information from the patient including previous names, addresses etc.
- Compare this information, together with any previous history with that contained on the MPI/PAS and within the available case notes.
- Contact MROS liaison team with the patient identifiers (PID numbers), but no patient identifiable details (eg name) and advise them of a potential duplication of records.
- Continue recording the current patient activity within the available case notes but return these to **Trust Health Records Team, ICT Services** (not TNT)
- The Trust Health Records Team will undertake the appropriate searches and will merge the patient's details on MPI as well as ensuring that the patient has one complete physical health record.
- Any concerns about potential amalgamations should be addressed to MROS liaison team

Appendix 7

HEALTH RECORDS PROCEDURE 5(v1)

MERGING OF IDENTIFIED DUPLICATE REGISTRATIONS

Aim

To ensure that the Master Patient Index (a shared instance with George Eliot Hospital and Coventry Partnership Trust) and the National Spine (PDS – a national demographic database which holds the details of all patients registered with a GP) is kept accurate and any duplicate registrations are merged promptly in accordance with national guidelines.

To ensure that all relevant paper health records are also merged in line with the MPI/PAS.

Process

- All merging of patient demographic information and activity will be undertaken on iPM by members of the Trust health records team
- The Health Records Manager (in association with the Trust's Information Department) will be responsible for routinely producing computerised lists of patients who have more than one record
- The Trust health records team will undertake extensive searches to ensure that the correct patient details are recorded under the appropriate unique PID.
- Continue recording the current patient activity within the available case notes but return these to **Trust Health Records, ICT Services** (not TNT)
- The Trust Health Records Team will undertake the appropriate searches and will merge the patient's details on MPI/PAS as well as ensuring that the patient has one complete physical health record.
- Any concerns about potential amalgamations should be addressed to the MROS liaison team

Appendix 8
HEALTH RECORDS PROCEDURE 8(v2)
TRANSPORTATION AND USE OF RECORDS ON AND OFF-SITE

Aim

To ensure that all Health Records belonging to UHCW are transported and used in a safer, secure and confidential manner at all times.

Process

- Health Records should only be used for authorised activity on behalf of UHCW.
- Movement of health records should only be undertaken by TNT (contractor) or ISS portering services (where applicable) or Royal Mail (recorded delivery)
- Any other movement of health records should be approved by the Trust Health Records Team and the tracking module on iPM **MUST** be updated accordingly.
- The Trust Health Records Team can be contacted by email to MROS liaison team and should be given full details of the records and their delivery requirements.
- Once approval has been given the Trust Health Records Team will either contact TNT and request them to transport the records, or will authorise ISS to collect.
- Under no circumstances must UHCW records be given to patients/relatives/guardians or carers if the patient is being transferred from one UHCW location to another UHCW location (including across UH and Rugby sites). When patients are being transferred the records must be moved by Trust staff (including volunteers), or if timeframes allow, TNT staff or ISS Portering Services. The only exception given is where obstetric patients, who attend Maternity Reception at UHCW, are provided with their Health Records in a sealed bag (Normally a TNT blue bag) to take to Labour Ward only. If a patient is attending any other location e.g. pre-op, clinic, scan, the records must not under any circumstances be given to the patient to transport. Prior to the Labour Ward patient being given their records, Maternity Reception staff must check there are no safeguarding issues with that patient. If there are safeguarding issues, the patient must not be given their records and Trust staff must transport them to Labour Ward. If any issues or breaches are witnessed by Trust staff, i.e. the patient is seen opening the blue bag, or the blue bag has been tampered with on arrival at Labour Ward, the incident must be reported on Datix immediately.
- Any Health Records which are moved without the above authorisation will not be covered by the terms and condition of the Health Records contract and the member of staff responsible will become liable for any damage or loss of the records concerned.
- The last person to whom a set of notes is tracked is responsible for producing them when required.
- Please also refer to Appendix 14 Process for other external initiatives and Appendix 15 Process for taking records/data off site.

Appendix 9

HEALTH RECORDS PROCEDURE 9(v2)

LOOSE FILING IN RECORDS

Aim

To ensure that the health record contains **all** approved documentation relating to the patients' condition and treatment, and to ensure that the health record is always kept in up-to-date with any additional information that is generated during, or relating to, the patients' attendance(s) at the Trust.

To ensure that this documentation is filed in the correct position within the clearly defined section in the Health Record.

Process

- It is the responsibility of **every user** of the Health Record to ensure that they file any document that they use or generate into the Health Record at the time that the documentation is generated or the information is recorded.
- If the health record is not available the documentation should be kept clipped together, clearly marked with the patient's details, including their PID number.
- As soon as the health record does arrive all documentation should be filed within the health record in the correct position (in accordance with the instructions clearly marked within the case note folder).
- The health record should not be returned to TNT for filing with documentation loose within the case note folder.
- Loose filing should not be returned to TNT separately if the health record is available with the user.
- Loose filing which has to be returned to TNT without the health record should be placed within an envelope which is clearly marked "**Loose filing for TNT"** together with name of user sending it, location being sent from and date sent.
- The envelope should then be placed in a TNT orange or blue box at your nearest scan point for return to TNT. The envelope should not under any circumstances be placed into the iSS Trust internal postal system.
- TNT will advise the Trust Health Records Team of users who do not follow the above process.

Appendix 10

HEALTH RECORDS PROCEDURE 10 (v1)

G.P. E- DISCHARGE LETTERS AND DIGITAL DICTATION CLINICAL CORRESPONDANCE

Aim

To ensure that there is no duplication of documentation within the health record and that patient information which can be maintained and accessed electronically is not contained within the health record.

Process

E-Discharge

- All E- GP discharge letters must be created on the Clinical Results Reporting System.
- Once the letter has been approved by the consultant the letter must be marked completed.
- Once completed the letter will become available to all users with access to view, including GPs, via the clinical letters tab.
- Letters are listed, in reverse order, by date of clinical activity.
- Letters should not be printed: GP's will receive letters electronically if linked via ET or will they receive paper copy distributed by CfH. A Letter should only be printed if they are being given to the patient on discharge.
- Copies of letters should not be filed within the health record. (Any GP discharge letters that are not modified and sent to TNT will be confidentially destroyed).

Digital Dictation

- All letters created and verified via the Digital Dictation System will be automatically stored on CRRS
- Once completed and verified the letter will become available to all users with access to view, including GPs, via the clinical letters tab.
- The system will indicate where a letter should be printed. Coventry and Warwickshire GP's will receive letters electronically via EDT. A paper copy can be printed if the GP is not linked to EDT (system will indicate) or there is a requirement for a patient or other recipient copy.
- Copies of letters should not be filed within the health record.

Appendix 11

HEALTH RECORDS PROCEDURE 11 (v2)

REQUESTING/DELIVERY OF RECORDS

Aim

Any patient attending the Trust for planned activity i.e. appointments or elective admissions (TCI's) placed on to the PAS more than 48 hours prior to the activity, will have a request for the records to be delivered to the appropriate location sent to the health records service provider. An automatic electronic pulling list will be sent on a daily basis, via a secure ftp process. The list for appointments will be sent 7 days prior to the appointment, with 'late additions' sent up to 24 hours prior to the activity. The list for TCI's will be sent 10 days prior to the TCI, with 'late additions' sent up to 24 hours prior to the activity.
Any appointments or TCI's placed onto the PAS less that 48 hours prior to the activity, will require the records to be requested by the user via e-form.
Records required for other purposes e.g. review, audit, complaints, MDT etc will require the records to be requested via e-form.
Full guidance on the operational management of records, including requesting timeframes and priorities can be found in the 'Survival Guide to Health Records' which is located via the Trust intranet site under 'departments/ department listings/health records services/Health Records Survival Guide'.

Process

- Appointment/TCI placed on PAS. If activity more than 48 hours in advance, request sent via ftp to service provider. Automatic list produced from UHCW staging database extract data.
- If appointment/TCI less than 48 hours in advance, records must be requested via e-form (found on UHCW Intranet under e-forms/health records/case note request form).
- Records required for 'other' activity must be requested via e-form (please see instructions above).

Appendix 12

Health Records Procedure 12 (v2)
RETENTION, DISPOSAL AND DESTRUCTION OF RECORDS

Aim

The Trust's Health Records Management Policy has been amended to reflect the new NHS Code of Practice Part 2, where UHCW records (with exceptions) will be retained for 30 years.
The process is in association with the health records service provider, and the Trust health records team.

Process

- The health records service provider will identify records held in the store (by the year sticker) on instructions from the Trust health records team regarding year(s) to pick.
- The records identified by the service provider will be segregated at the store.
- Specifically trained service provider staff will view the records, ensuring every page is scrutinised.
- Any records that have documentation for any dates/years later than the year(s) instructed, will have a year sticker (year pertaining to the year of activity) placed on the folder, and possible year of destruction indicated on the volume folder, and volume returned to store
- Records that meet the destruction criteria will have the PID and volume number recorded (to be kept in the destruction spreadsheet saved on the ICT server), and further segregated.
- The Trust health records team will select a sample of the records selected (minimum 10%) to be delivered to ICT Services building.
- The Trust health records team will view and scrutinise the selected records to ensure no documents are dated later than the year(s) instructed.
- If any records are found to have documentation later than the year(s) instructed, they will be segregated and returned to store with the date of destruction indicated on the volume folder.
- The PAS will also be updated to record the volume has been destroyed.
- The health records service provider will record on their IT system records identified for destruction.
- Records identified for destruction will be signed off by the UHCW health records manager (or deputy), and the health records service provider contract manager.
- Records will be collected by the approved destruction company, accompanied by the health records service provider security manager.
- The health records service provider security manager will witness the safe 'shredding' of the records until completed.
- The destruction company will issue a 'certificate' when completed.

Disposal

- Any records that do not yet meet the destruction date ie retained for 30 years, but are no longer 'active', will be stored as 'archived' records at the service provider store, on a shelf. The location of the record will be recorded on the PAS, and on the service providers system (via barcode technology).

Appendix 13

Health Records Procedure 13 (v1)

Process for BMI PRIVATE PATIENTS

Aim

To ensure the process for the management of records for BMI Private Patients who receive procedures at UHCW as part of the BMI/UHCW contract for specific operations, is clear and understood by both UHCW and BMI staff.
To ensure the process for the management of records for UHCW NHS patients who have consultations/operations at BMI as part of the UHCW initiatives for e.g. 18 week wait patients, is clear and understood by both UHCW and BMI staff.

Process

- For BMI Private Patients who are treated at UHCW for specific procedures (not available/supported at the BMI site), will have their UHCW health records available at the point of 'admission' to UHCW. The BMI health record will be transported to the appropriate UHCW ward by BMI staff. All nursing and clinical documentation pertaining to the patient that is currently held within the case note will be recorded in the UHCW health record. This documentation will be photocopied by the relevant UHCW staff and placed within the BMI record prior to their return to BMI, as the activity has been undertaken on behalf of BMI (and charged for accordingly). The original paperwork will be retained within the UHCW record.
- For UHCW NHS patients who receive consultation/treatment at BMI as NHS UHCW patients during a specialty initiative (e.g. 18 week wait), will have the UHCW health records requested via the UHCW PAS automatic pulling list sent via secure ftp to the UHCW health records service provider (as this activity is UHCW's and recorded on the PAS). The UHCW health records service provider will deliver the records to BMI at the appropriate delivery date. BMI staff will ensure copies of the paperwork are filed in the appropriate section of the UHCW record. When the patient has been treated, the records will be collected by the health records service provider and re-delivered to the UHCW Clinical Coding department, to enable the consultant episode to be coded. The records will then be returned to the health records service provider for storage/until next required.

Appendix 14

Health Records Procedure 14 (v1)

Process for other External Initiatives

Aim

To ensure the process for the management of records for UHCW NHS patients who have consultations/operations at other external providers as part of the UHCW initiatives for e.g. 18 week wait patients, is clear and understood by both UHCW and external provider staff.

Process

- For UHCW NHS patients who receive consultation/treatment at other external providers as NHS UHCW patients during a specialty initiative (e.g. 18 week wait), will have the UHCW health records requested via the UHCW PAS automatic pulling list sent via secure ftp to the UHCW health records service provider (as this activity is UHCW's and recorded on the PAS). The UHCW health records service provider will deliver the records to the external provider at the appropriate delivery date. External provider staff will ensure copies of the paperwork are filed in the appropriate section of the UHCW record. When the patient has been treated, the records will be collected by the health records service provider and re-delivered to the UHCW Clinical Coding department, to enable the consultant episode to be coded. The records will then be returned to the health records service provider for storage/until next required.

Appendix 15

Health Records Procedure 15 (v1)

Process for Taking Records/Data Off Site

Aim

To ensure University Hospitals Coventry and Warwickshire NHS Trust adheres to the advice provided by the Information Commissioner regarding security and confidentiality of records and patient/sensitive information, and is compliant with the Data Protection Act. The following guidelines have been compiled for staff who, in the course of their duties to provide patient care, or for audits of records/information off site undertaken by Ofsted, Care Quality Commission, or other NHS regulatory bodies, are able to follow processes that protect both paper and electronic data.

Process

The following guidelines have been issued by the Trust Senior Information Risk Owner (SIRO):

- All patient records should be kept in appropriate lockable box or briefcase in the car boot
- When travelling – all paperwork should be kept in a locked car boot
- Patient information should not be transported using public transport
- Patient identifiable information should not be left in a car unaccompanied
- Wherever possible use PID's – not patient names on a schedule or list
- For home visits keep all patient information in a locked briefcase and only take out the record pertaining to that visit
- Staff will be required to return any documents containing patient data to one of the Trust sites when a visit/clinic is completed. If this is not possible, the documents remain in the locked briefcase in the staff member's home (not left in the car overnight).
- Where a lockable box or briefcase is being used, any information on an encrypted memory stick, or a CD should also be kept in the lockable box/briefcase.

Staff taking data off site in support of their duties should adhere to the following:

- ICT Security Policy
- The Trust Confidentiality Policy
- Home working Policy

Where a member of staff is required as a course of their duties to take records off site it is the line managers' responsibility to ensure they are doing so in accordance with this procedure and where necessary the service should provide the necessary secure storage/briefcase from within their department budgets. Information on the options available and associated prices can be obtained from the Supplies Department.

UHCW Health Records

UHCW health records taken off site for the provision of patient care will be tracked on the PAS (iPM) to either:

- The end location e.g. satellite clinic which will be set up on request by the Trust health records team (if not already available) for regular off site activity

- The member of staff's UHCW department tracking location, with a comment including the travelling arrangements, end location and emergency contact phone number, for irregular or patient home visits.

Documents/Paperwork Containing Patient/Sensitive Information (ie Not Complete UHCW Health Record Volume)

Patient or sensitive information e.g. assessment forms, history sheets, nursing records that are taken off site must be secured in a lockable box/briefcase, following the SIRO guidelines above.

Records Taken Off Site for Audits

UHCW records taken off site for audits by NHS bodies such as Ofsted, Care Quality Commission or Child Protection Conferences, must complete the proforma (appendix 1), and forward to the Trust health records team prior to the records being taken off site. A specific spreadsheet for use to request the records will be provided by the Trust health records team to the requestor.

In these circumstances, whether the records will be off site for the period of one day, accompanied by Trust staff, or left in other NHS premises (securely), the records must be tracked on the PAS (iPM) to the end location (tracking location will be set up by Trust health records team), with a comment including the name of the Trust member of staff transporting the records, travelling arrangements, and in the case of records being left in other secure NHS premises, arrangements and 24 hour contact details in the event the records are required as an emergency. If such arrangements cannot be made, UHCW will not authorise records to be left in other NHS premises overnight (albeit securely). Records must be obtainable if required.

Proforma for Records to be Taken Off Site for NHS Audits/Case Conferences

Date of Request	
Department Requesting Authorisation	
Specialty	
Staff Name Responsible	
Reason for Request	
Date of Audit/Case Conference	
Number of Patient Records Being Taken Off Site	
Name of NHS Body/Case Conference	
Name of NHS Body Responsible Member of Staff	
End Location Address	
Emergency Contact Details – Trust	
Emergency Contact Details – Non-Trust	
Number of Days Records Off Site	
Transport Arrangements	
Spreadsheet Requesting Records sent to TNT	Date
Is an iPM Tracking Location Required	Y/N
If Yes – description	
Date Tracking Location Set Up	
All Volumes of Records to be Tracked to End Location by – staff name	
All Volumes of Records to be Tracked back to UHCW Location on Return by – staff name	

Appendix 16

Health Records Procedure 16 (v1)

Process for the Implementation of Phase I Day Forward Scanning of Health Records Forms

Aim

To provide guidance on the implementation of current episode (day forward) scanning of health records paperwork in phase I of the implementation plan.

Process

- For the phase I specialties/areas, where health record case notes are currently delivered, this will continue (where clinically required), but the case notes will be used for reference purposes only. Any paperwork generated during the episode will not be filed into the case note.

- Health records forms (where they have been submitted by specialties to the EDM Team prior to phase I) will be provided by Harlow Printing (as per current ordering process) with a 2d document type bar code on the bottom left and right of the form. Locally produced forms that are to be located on e-library or specialties local PC drives, where submitted, will have the 2d document type bar code allocated, where possible. For external correspondence/test results and National Forms, the use of a header sheet by Trust staff will be required to indicate where in the EDM the images should be placed.

- The scanning supplier will provide 'scanning folders' for all pre-planned/elective patient activity. All patient specific scanning folders should be tracked in on the PAS (tracking the S0- case note folder). This scanning folder will be patient specific, and all health record forms (that would normally be filed into the case note) that are completed during the episode (end of clinic consultation or on inpatient/day case discharge) should have a PID label placed onto specified areas on the form, and the forms placed into the patient specific scanning folder for that patient (not the case note volume). Patient specific scanning folders should be tracked out on the PAS to the scanning bureau. All completed scanning folders should be placed at the scanning collection location. The scanning supplier will collect all completed scanning folders at pre-determined collection times, deliver to the scanning bureau, and the paperwork will be available as scanned images within the EDM by 8am the following day.

- For emergency/walk in patients, bar coded forms should be used (in the same way as for pre-planned/elective activity), and a supply of blank (non-patient specific scanning folders) will be available at clinical locations to allow paperwork generated to be placed safely into a folder. These folders will not be able to be tracked on the PAS as they are not patient specific. Paperwork for one patient only should be placed into scanning folders, whether patient specific or not.

- For specialties/areas not included in phase I, health record case notes will continue to be delivered (where clinically required) and used as per usual i.e. paperwork generated should be filed into the case note if the case note is available.

- NB: 2d document type bar codes may already be in circulation in non-phase I areas, and should be used as 'normal' forms.

- Specialties/areas not included in phase I should be aware a patient may have been treated in a phase I specialty/area and may have scanned images available within the EDM.

NB: Any forms that do not have a PID label attached will be returned to the location where the forms were completed.
The scanning process requires a pre-printed PID label on one side of every sheet. If a multi-page document, PID labels should be placed on pages 1, 3, 5 ,7 etc.

- Day forward paperwork once scanned will be held by the scanning supplier for 3 months and then confidentially destroyed.

Appendix 17

Health Records Procedure 17 (v1)

Process for the Implementation of Day Forward Scanning Rest of Trust

Aim

To provide guidance on the implementation of current episode (day forward) scanning of health records paperwork following the completion of phase I i.e. rest of Trust.

Process

- Where health record case notes are currently delivered, this will continue (where clinically required), but the case notes will be closed i.e. no paperwork should be filed into the case notes.

- Health records forms (where they have been submitted by specialties to the EDM Team prior to go for the live rest of Trust) will be provided by Harlow Printing (as per current ordering process) with a 2d document type bar code on the bottom left and right of the form. Locally produced forms that are to be located on e-library or specialties local PC drives, where submitted, will have the 2d document type bar code allocated

- The scanning supplier will provide 'scanning folders' for all pre-planned/elective patient activity. All patient specific scanning folders should be tracked in on the PAS (tracking the S0- case note folder). This scanning folder will be patient specific, and all health record forms (that would normally be filed into the case note) that are completed during the episode (end of clinic consultation or on inpatient/day case discharge) should have a PID label placed onto specified areas on the form, and the forms placed into the patient specific scanning folder (not the case note volume). Patient specific scanning folders should be tracked out on the PAS to the scanning bureau. All completed scanning folders should be placed at the scanning collection location. The scanning supplier will collect all completed scanning folders at pre-determined collection times, deliver to the scanning bureau, and the paperwork will be available as scanned images within the EDM by 8am the following day.

- For emergency/walk in patients, bar coded forms should be used (in the same way as for pre-planned/elective activity), and a supply of blank (non-patient specific scanning folders) will be available at clinical locations to allow paperwork generated to be placed safely into a folder. These folders will not be able to be tracked on the PAS as they are not patient specific. Paperwork for one patient only should be placed into scanning folders, whether patient specific or not.

NB: Any forms that do not have a PID label attached will be returned to the location where the forms were completed.
The scanning process requires a pre-printed PID label on one side of every sheet. If a multi-page document, PID labels should be placed on pages 1, 3, 5 ,7 etc.

- Day forward paperwork once scanned will be held by the scanning supplier for 3 months and then confidentially destroyed.

Appendix 18

Health Records Procedure 18 (v1)

Process for the Scanning of Legacy Records

Aim

To provide guidelines regarding the scanning of specific legacy records which will take place at the end of phase I and continue during an agreed SLA timeframe.

Process

- Legacy scanning will be undertaken for specified specialties and long retention diagnosis and conditions. Long retention records will be identified (where possible) by electronic data collection from the PAS and other IT systems.

- Records for active patients in these specialties will be identified in advance of patient activity to the health records service provider, who will pick/chase and make available for collection. The scanning provider will collect, deliver to the scanning bureau, and scan within SLA timeframes.
- Mechanisms will be in place if particular records are required urgently e.g. patient has been admitted as an emergency to expedite scanning to ensure images are available.

- All volumes for these identified patients will be scanned, and the physical case note volumes will be kept for 3 months following scanning in a non-constituted format, then confidentially destroyed.

- Scanning of identified deceased records will be undertaken during an agreed SLA timeframe.

- Once scanned, all images will be available within the EDM.

Appendix 19

Retention and Destruction HSC 291514 (Records Management: NHS Code of Practice – Part 2) (v1)

Minimum Retention Periods

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Procedures\Minimum I