GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	WAO Clinical Coding Follow-up Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Karen Miles, Director of Planning, Performance, Informatics and Commissioning
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Assistant Director of Informatics

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide an update to the Audit & Risk Assurance Committee (ARAC) on progress in implementing the Wales Audit Office follow-up review of Clinical Coding within Hywel Dda (1175A2019-20) and the Internal Audit Reporting into health records (HDUHB-1819-33).

Cefndir / Background

In April 2014, the WAO reported their findings for Hywel Dda and concluded that the Health Board gives clinical coding a high profile, supporting it with a good level of investment, and is focused on improving the quality of management information although further improvements to local practices are required. More specifically, they found that:

- the importance of clinical coding to support the effective operation of its business was recognised in the Health Board although more needed to be done to raise the profile of medical records and focus on accuracy.
- many aspects of the clinical coding process were sound however clinical engagement was sometimes lacking, medical records were often poor, and some records took a long time to be coded.
- clinical coded data was used appropriately and met the Welsh Government standards for timeliness and completeness, however some coding was inaccurate, and the Board were not aware of the inaccuracies or its implications.

As a result, WAO made several recommendations, which focused on the need to:

- improve the management of medical records;
- strengthen clinical coding resources;
- further build Board engagement and resources; and
- strengthen engagement with medical staff.

As part of the Auditor General's 2018 Audit Plan for the Health Board, WAO have examined the progress made in addressing the recommendations set out in the 2014 Review of Clinical Coding and any resulting improvement in performance. They concluded that coding continues to be a

low priority for the Health Board and non-compliance with the completeness target is impacting on overall improvement in accuracy and staff morale. The use of coding data as business intelligence remains underdeveloped and there is still considerable room for progress against their previous recommendations.

Asesiad / Assessment

The Committee received an update at their June 2019 and October 2019 meetings, and this paper provides the progress to date against the timelines. In order to provide a composite view of all the recommendations, Appendix 1 brings together the recommendations of the WAO and the Internal Audit reports, and then these have been further sub-divided into specific proposed Director leads, to ensure ownership. The Health Records Group, which is a group of IGSC was tasked to action the Health Records elements, and the IGSC will consider the clinical coding elements within the already established standing agenda item. A summary of the actions and their RAG status is included below:

Previously Reported

Audit Report	Complete	In Progress	Overdue	Total Recommendations
Wales Audit Office Report - 1175A2019-20	4	6	5	15
Internal Audit Report (HDUHB-1819-33)	-	-	-	-
Total	4	6	5	15

Updated as at September 2019

Audit Report	Complete	In Progress	Overdue	Total Recommendations
Wales Audit Office Report - 1175A2019-20	8	7	0	15
Internal Audit Report (HDUHB-1819-33)	7	2	0	9
Total	15	9	0	24

Updated as at April 2020

Audit Report	Complete	In Progress	Overdue	Total Recommendations
Wales Audit Office Report - 1175A2019-20	10	3	2	15
Internal Audit Report (HDUHB-1819-33)	7	1	1	9
Total	17	4	3	24

Due to the COVID outbreak, the work associated with many of the recommendations has been delayed by at least 3-4 months.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to note the contents of this report

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	No specific risk are contained within the document, the projects outlined are reflected within the Informatics and Corporate Risk Register. Risk Register Reference 371, with a risk score of 20
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology 5. Timely Care 3.5 Record Keeping
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Business Planning and Performance Assurance Committee Information Governance Sub-Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	The lack of clinical coding information impacts the statutory costing returns
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Poor quality data could result in misidentification of patients along with service changes without a full accurate picture The lack of clinical coding records affect the use of data for secondary uses, such as audit, mortality reviews
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Appendix 1 – Composite table of the WAO (1175A2019-20) and Internal Audit (HDUHB-1819-33) Recommendations

Recommendation / Finding	Original Reporting Status	Summary of progress / Management Response	Lead Director and Officer	Target date for implementation	September 2019 update
Wales Audit Office Report - 1175A2019-20					
Management of Medical Records **R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include:**					
a) improving engagement between the medical records and clinical coding teams.	In progress	Clinical coding staff reported good relationships with health records staff across the Health Board. The Clinical Coding Manager recently met with the Health Records Manager for Carmarthenshire to discuss the processes in place between health records and clinical coding. They were satisfied that they were working well. Clinical coding staff pull the majority of case notes from the filing libraries at Glangwili Hospital, Prince Philip Hospital, and Bronglais Hospital. Coding staff at Withybush Hospital can ask health records staff at Prince Philip Hospital to pull notes to be sent to the relevant site for coding. Access to the health records library at Withybush Hospital has been restricted through the introduction of locks. Clinical coders do have access although they must ring to gain entry. This slows down retrieval of case notes. The Director of Planning, Performance, Informatics and Commissioning intends to strengthen the Health Records Group to provide a focus for issues associated with effective health records management.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics / Deputy Director of Operations	Included in a wider action plan for Health Records to be developed by August 2019	Complete. The Clinical Coding Manager and Head of Health Records, and Deputy Health Records Managers are members of the Health Records Group, and processes have been agreed to ensure that access to notes is improved.
b) removing the use of temporary records, including poly-pockets and ensure files are merged into the master patient record.	Overdue	Temporary notes and poly-pockets are still in use across the organisation. The Health Board's self-assessment response indicated that the numbers received into coding offices are not high. However,	**Lead Director(s)** Director of Planning, Performance, Informatics and	Included in a wider action plan for Health Records to be agreed by September 2019, with an implementation plan for	In Progress An action plan has been developed via the Health Records Group (please see

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		clinical coders across the Health Board told us that the situation had deteriorated over the period since our last review. There has been a decline in the organisation, maintenance and condition of individual patient case note folders because of greater movement of patients around the Health Board and shorter lengths of stay. Both factors add to the challenge of ensuring the notes are maintained in line with standards, and available when needed by clinical coding teams as well as clinicians. A note is entered in Medicode whenever a poly-pocket is used as the source for coding. If an audit of the full case note is subsequently carried out, there will then be a flag to indicate that it was not available at the time of coding.	Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics / Deputy Director of Operations	completing the engagement and enforcement work to be completed within 8 months from agreement of policy	Appendix 2) The Health Records Group has agreed to focus on the correct Tracking of Patient Records, with Temporary notes and poly-pockets looking to be addressed following this work **Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020**.
c) reinforcing the Royal College of Physician standards across the health board.	In progress	A clinical coding PowerPoint presentation was due to be emailed to all consultants at the time of our fieldwork. This was to include the 'Royal College of Physicians Top ten tips for coding – a guide for clinical staff'. It is a one-off occurrence. We are not aware of ongoing activities to ensure that the standards are promoted.	Lead Director(s) Medical Director **Lead Officer(s)** Assistant Director, Medical Directorate	This action is subject to a follow-up internal audit report, where a full action plan will need to be developed	Complete
d) providing training for ward clerks and other staff in relation to their responsibilities for medical records.	Overdue	There is no ongoing programme of training to ensure that ward clerks maintain records in line with professional standards. Coding staff said that the standard of practice amongst ward clerks is highly variable, and there is no real ownership of the notes in some wards. Ward clerks are managed by individual specialties and wards. This increases the need for ongoing communication (with ward staff in general as well as with ward clerks) about the importance of maintaining standards of practice and for the provision of training.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics /	Included in a wider action plan for Health Records to be agreed by September 2019, with an implementation plan for completing the engagement within 8 months from agreement of plan	In Progress The Head of Information Governance and Head of Health Records have agreed that joint IG and Health Records training will commence from January 2020. Rooms are currently being secured at each site to allow staff to attend. Staff will be trained in IG at the same time to improve the IG compliance.

Recommendation / Finding	Original Reporting Status	Summary of progress / Management Response	Lead Director and Officer	Target date for implementation	September 2019 update
			Deputy Director of Operations		We anticipate this work will take 4-6 months to complete with a number of sessions being held in all sites. **Original Timescale: - Sept 2019** **Revised Timescale – Training to begin December 2019 for 4-6 months** **Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020**
e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	Overdue	All the clinical coding teams are asked to track case notes correctly using the Myrddin Patient Administration System. The Health Board's self-assessment indicated that this always happens, except for when case notes are collected from a ward in the morning and returned that afternoon. However, coding staff indicated that case note tracking is generally poor, except at Withybush Hospital.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director of Operations	Included in a wider action plan for Health Records to be agreed by August 2019, with an implementation plan for completing the engagement within 12 months from agreement of plan	In Progress An action plan has been developed via the Health Records Group (please see Appendix 2) The Tracking of Records will be the focus of the Health Records Group for the next 6 months with a review at the end of this period along with lessons learned. The work plan suggests a number of phases to the work, ensuring that there are feedback loops and reviews. **Timescale – 16 months, based around 4 x 4 month PDSA cycles** **The first PDSA cycle was undertaken and lessons**

Recommendation / Finding	Original Reporting Status	Summary of progress / Management Response	Lead Director and Officer	Target date for implementation	September 2019 update
					learned have been feed into the next PDSA cycle, which unfortunately was paused due to the COVID outbreak. **It is anticipated that there will be a delay of 3-4 months**
f) putting steps in place to ensure that coders have early access to medical records for patients transferring to South Pembrokeshire Hospital prior to transfer.	Implemented	An internal process has been established to inform the coding department about patients who are to be transferred to South Pembrokeshire Hospital (SPH). The relevant case notes are then coded before the patient leaves the site. A coder visits SPH once a month to code any episodes which have been missed.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning **Lead Officer(s)** Assistant Director of Informatics	Complete	Complete
Clinical Coding Resources **R2 Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include:**					
a) reviewing the supervisory arrangements for Prince Philip Hospital to ensure that staff do not feel isolated.	Implemented	Clinical coding management team arrangements have been strengthened since our previous audit. This includes the appointment of a Clinical Coding Manager with responsibility for all coding teams and two coding team supervisors, one at Withybush Hospital and the other who supervises at Bronglais, Glangwili and Prince Philip hospital. However, arrangements have been significantly compromised by prolonged sickness absence of the supervisor covering three sites, and despite the introduction of mitigating interim arrangements. While staff at Prince Philip Hospital commended the Clinical Coding Manager for the cover he has personally provided, the situation has affected their morale. In	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning **Lead Officer(s)** Assistant Director of Informatics	Complete	Complete

Recommendation / Finding	Original Reporting Status	Summary of progress / Management Response	Lead Director and Officer	Target date for implementation	September 2019 update
		addition, consultants do not appear to be interested in the work that they do.			
b) extending the range of clinical information systems that coders have access to, including the operating theatres system.	In progress	The clinical coding team have access to the operating theatres module of the National Patient Administration System. However, there is inconsistent clinical practice in the use of the theatres module, NPAS functions in general, and other key systems that support the coding process like ChemoCare3 and the Welsh Clinical Portal. Work had recently commenced to examine whether there are additional systems which could be utilised by the coding team to assist in the coding process. It was too early for any findings to be made available. Second computer screens are gradually being made available to individual clinical coders to assist and expedite the coding process.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning **Lead Officer(s)** Assistant Director of Informatics	Complete	Complete
c) ensuring all staff receive consistent feedback on issues raised through validation and audit from all sites.	In progress	None of the coders are currently qualified to audit coding work. In 2017-18 it was decided to have a supervisor and a coder carry out an audit of 30 case notes each month and to feedback the results directly to individual coders. The arrangement was suspended so that all coding team resources could be directed towards clearing the coding backlog. At the time of our fieldwork the situation had not changed. The Coding Manager carries out data quality checks when time allows. However, his time has been heavily committed to providing a presence on each site to mitigate for the long-term sickness absence of one of the two coding team supervisors.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning **Lead Officer(s)** Assistant Director of Informatics	Until additional resources are made available this recommendation will be placed on hold. If the Executive Team wish this to be progressed, there will be effect on the coding completeness. As an estimate, in total each day a coding supervisor and a coder undertake audit work would account for 12,000 cases not being coded. Based on each coder having feedback and partaking in 1 audit day per month. This equates to a 1-2% effect on the completeness	Partially Complete. The Clinical Coding Team are undertaking minimal audits in line with NWIS, and these are being feedback to coders when available.
d) reconsidering the responsibility for typing discharge letters at Withybush to ensure that this duty does not impact on the	Implemented	Discharge letters are no longer typed by the clinical coding team at Withybush Hospital. Coders time is now entirely spent on coding episodes.	**Lead Director(s)** Director of Planning, Performance, Informatics and	Complete	Complete

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clinical coding process and the use of coding resources.			Commissioning **Lead Officer(s)** Assistant Director of Informatics		
Board Engagement/Resources **R3 Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood. This should include:**					
a) providing training for board members to raise their awareness of clinical coding and the extent to which it affects the quality of key performance information, other than mortality data.	Overdue	There is no evidence of training for board members to raise their awareness of the importance of clinical coding.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Board Secretary **Lead Officer(s)** Assistant Director of Informatics	The Director of Planning, Performance, Informatics and Commissioning will request a slot on a Board OD session to provide an update on clinical coding and some basic understanding the current process, and the impact on secondary uses. Awaiting confirmation of Board OD session	In progress Awaiting confirmation from the Board Secretary for a possible date for the Board OD Session An OD Session was booked in for February 2020, however it was postponed at short notice, a new date is awaited
b) improving information to board on the accuracy of clinical coding.	Implemented	The Board regularly receives information about coding performance (see also paragraph 21) as part of the Integrated Performance Assurance Report. It has previously received a copy of the NWIS clinical coding accuracy report. Information on coding accuracy is also provided on a regular basis to the Information Governance Sub-Committee.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning **Lead Officer(s)** Assistant Director of Informatics	Complete – included within the Integrated Performance Assurance Report provided to every Board	Complete
Engagement with medical staff **R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:**					
a) embedding a consistent approach to clinical coding training for medical staff across the health board;	Overdue	Medical staff do not receive training in relation to clinical coding. An introduction to clinical coding was previously included in the induction process for new junior medical staff, but it is unclear whether this is still the case. In the months prior to	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning	Further work is required to provide a detailed plan to ensure achievement of this recommendation. A scoping exercise to be	Complete A presentation has been circulated to all consultants and SDM for information and feedback. This is repeated twice

Recommendation / Finding	Original Reporting Status	Summary of progress / Management Response	Lead Director and Officer	Target date for implementation	September 2019 update
		our review the Clinical Coding Manager had sent a PowerPoint presentation on clinical coding to the Medical Director and the four hospital clinical leads with a request for feedback, with varying responses. The presentation is to be emailed to all consultants and service delivery managers for information and further feedback. A Chief Clinical Information Officer (a respiratory consultant) had been in post for eight months and has two sessions per week to devote to clinical information issues. He would like to establish sufficient resource amongst clinicians across the Health Board to advocate and promote good practice in relation to clinical coding. His intention is to strengthen clinical representation on the Clinical Informatics Group to help focus on problematic areas. One example is endoscopy, where there is a high volume of patients and low quality of notes. The Health Board recently approved a post of Chief Nurse Information Officer and planned to make an appointment to the post later in 2018. This will help to focus on note taking which will in turn support better coding.	Medical Director Director of Workforce and OD **Lead Officer(s)** Assistant Director of Informatics Assistant Director Medical Directorate Chief Clinical Information Officer	undertaken to fully understand to actions required October 2019	yearly, and after each junior doctor rotation.
b) reinforcing the importance of completing timely discharge summaries	In progress	The Health Board has been slowly rolling out electronic patient discharge arrangements, although it is still only available in a limited number of areas. Coding teams said that where this is in place, the quality of information entered in to the system is generally poor. There is a cyclical issue which arises because of junior doctor intakes, which means that expected standards must be learned each time. Coding staff also indicated that electronic system updates can be problematic. Coding staff said that the timeliness and quality of	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Medical Director Deputy Chief Executive/ Director of Operations	A high level targeted improvement plan has been developed in response to the need to improve the usage of National Systems within the Health Board. For those ward areas that have access to Medical, Transcribing and eDischarge (MTeD), it has been agreed that the Health Board will look to achieve 90% of all discharges as electronic.	Complete A new plan for the delivery of MTeD to all wards has been developed, but is paused due to the current COVID outbreak

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		written discharges is variable and has deteriorated over time. For example, they are often illegible or blank.	**Lead Officer(s)** Assistant Director of Informatics Pharmacy Lead Chief Clinical Information Officer		
c) improving clinical engagement with the validation of clinical coded data	In progress	There was little specific evidence of clinical engagement with the validation of clinical coded data.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Medical Director **Lead Officer(s)** Assistant Director of Informatics Assistant Director Medical Directorate Chief Clinical Information Officer	As outlined in Recommendation 2 (c)	Complete Engagement exists with Hospital Directors, specifically around mortality and Interventions Not Normally Undertaken (INNU) is on the Scheduled Care agenda.
Internal Audit Report (HDUHB-1819-33)					
Finding 1 (O) - Corporate Records Management Strategy & Policy - Management should ensure the Corporate Records Management Strategy and Policy are submitted to the Business Planning & Performance Assurance Committee for approval.					
We can confirm that the *Health Records Management Strategy* and *Policy*, and *Retention & Destruction Policy* had been submitted for approval at the Business Planning & Performance Assurance Committee meeting in June	Medium	Following internal discussions, the Corporate Office is leading the review and updating of the Corporate Records Management Strategy and Policy. This will require contributions and input from a number of teams across the UHB. Once reviewed, these will be submitted to the Business Planning & Performance Assurance Committee at the earliest opportunity.	**Lead Director(s)** **Lead Officer(s)** Head of Corporate Office	September 2019	In progress An SBAR report was submitted by the Corporate Office to the Information Governance Sub Committee (IGSC) on 17 May 2019. The report set out the current position of the Corporate Records

2018. However, the *Corporate Records Management Strategy* and *Policy* had not been submitted or approved at the time of fieldwork.					Management Policy and will highlight the risks identified. Corporate Office have identified that the policy requires a more strategic approach to its development as it is a Health Board wide policy, and shall recommend to IGSC that a task and finish group be established with a nominated lead, to take the policy forward. Further to this, it has been identified that the current Corporate Records Management Policy is not fit for purpose. A recommendation will be made to the IGSC for the policy to be removed from the Health Board intranet site until the policy has been thoroughly reviewed and submitted to the Business Planning & Performance Assurance Committee for approval **Original Timescale: - Sept 2019** **Revised Timescale – Dec 2019** **A revised policy was due to be consider at the March 2020 IGSC, however this was postponed due to current outbreak.**
Finding 2 (O) - Health Records Inventory - Identified Service and Departmental Managers should ensure a Paper Health Records Inventory Form is completed, regularly reviewed and forwarded to the Head of Health Records as set out in the Health Records Management Policy.					
The *Health Records Management Policy* states that an up-to-date records inventory will be maintained by the Head	High	(a) All Information Asset Owners (IAO's) have been identified via the Information Asset Owners Group which is organised by the Health Boards Information Governance Team. The IAO's have	**Lead Director(s)** All Directors **Lead Officer(s)** All Information	The work of the Information Asset Group is on-going. The Group aim to complete a new service within 3	Section (a) - In progress In order to better track and monitor progress with the

of Health Records, whilst Service/ Departmental Managers are required to ensure inventories are completed, regularly reviewed and forwarded to the Head of Health Records. However, there is currently no health record inventory in place with the last 'Paper Health Records Inventory Form' was received back in 2015.		clear responsibility for completing an Information Audit Template. Some of the information requested on the template includes: • Type of information held • Where the information is held • Legal requirements and classification of the information • How is the information shared • How is the information distributed Effectively over time the information gathered will support or potentially replace the inventory form as the list will be a Health Board wide database containing all IAO's and the relevant information. The Information Governance Manager is working directly with Directorates and lead IAO's to ensure the information is completed as quickly as possible. To date approximately 50% of responses have been received and the IG Manager will continue to work with individual leads to ensure those currently outstanding are completed as soon as possible. (b) This work is being supported by the Electronic Records Group which is being led by the Deputy Director of Operations. This group is looking at the potential to implement a scanned patient record within the Health Board and as part of the remit is developing a questionnaire which will again be completed by all relevant IAO's and will again cover records management arrangements within department and services but in addition will also identify any use of private storage companies and the costs. The questionnaire will be circulated to IAO's in January.	Asset Owners. Managed via the Information Governance Sub-Committee Health Records Manager	months on being identified. This work incorporates a full review of the information asset, the flow of the data / information and a full information audit as per the requirements of the General Data Protection Regulation (GDPR). This work has just been audited and received a "substantial assurance", and commended for the approach. The Health Records elements, will be included in a wider action plan for Health Records to be agreed by August 2019 Section (b) of the management response is completed	individual IARs and put more responsibility on the IAOs to drive this work, a template IAO Work Plan was circulated. Based on the most recent RAG update, 70% of IAOs have engaged in the process and are working towards compliance (31/44). The Information Governance Sub-Committee (IGSC) requested that the 13 IAO that have not engaged is escalated to the Executive Team. The compliance has now been included within the Executive Performance Reviews, and a number of IAOs have already begun to engage following the recent round of performance meetings A programme of in-depth refresher training is being rolled out for all IAO/IAAs to ensure they fully understand their information assets and the responsibilities that entails, including records management. This is being carried out in conjunction with ongoing work between IG and IAOs in developing a GDPR compliant Information Asset Register for each service area of responsibility. At the time of writing this update 65% of all IAO/IAAs (62/97) have undertaken the training **Original Timescale: - July 2019** **Revised Timescale – July 2020** **It is anticipated that there will**

					be a delay of 3-4 months and a revised date will be November 2020
Finding 3 (D) - Storage Capacity - We would recommend that management review current storage arrangements to establish whether they continue to be fit for purpose, whilst consideration should be given in the progression of other solutions for example, scanning of documents, to reduce the amount of manual health records retained by the Health Board.					
A copy of the 'Paper Health Records Inventory Form' was issued to a number of services/ functions/ teams within Mental Health, Nursing, Women & Child Health and Therapies directorates. A total of **50** services/ functions/ teams returned the completed inventory form with **40** stating they retained patient records and information locally. Of the 40 areas retaining local patient records, **26** highlighted the risk of insufficient storage available, whilst a number noted risks and concerns in relation to the current storage arrangements of records. The Health Board's in-house storage facility in Llangennech retains health records dating back to 2006 due to the current embargo on the destruction of records by the Welsh Government (applicable to all health boards across Wales) due to the blood contamination inquiry and also the Goddard inquiry. However, the storage facility is nearing full capacity, with a number of records stored in cardboard boxes alongside the outer walls on a temporary	High	(a) In November 2018 a records management brief was presented to the Executive Team highlighting a number of issues in various services across the Health Board. In addition to the issues a number of potential solutions were identified which could significantly improve current storage arrangements, increase efficiencies and also provide some potential savings. A follow up paper is being presented to the Executive Team on the 19th December 2019 and within the paper it clearly identifies future arrangements to deliver the solutions. The proposal is to have one overall project group with Executive leadership, with working sub group responsible for carrying out the work. As part of this process all services involved will be completing a detailed review of their current records management arrangements, storage arrangements and storage capacity. The project proposal should be finalised early in the New Year. (b) As identified in the earlier recommendation there is already a fully implemented Electronic Records Group within the Health Board. The group is led and chaired by the Deputy Director of Operations and will be responsible for the implementation of a scanned patient record within Hywel Dda. One of the main reasons why the group was implemented was due to the lack of storage capacity for	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director of Operations Health Records Manager	The Health Records elements, will be included in a wider action plan for Health Records to be agreed by August 2019 Sections (b) / (c) of the management response have been completed	Complete

basis while room is made available on shelving. The Health Record Departments risk register noted that it is working with the London Procurement Partnership to develop a business case for implementing a scanning solution. This approach has been implemented at Aneurin Bevan University Health Board where a Digitised Health Record (DHR) system was installed to enable the digitisation or scanning of patient case notes and make them available electronically, thus reducing storage space across the organisation.		storing records across the Health Board. The group is still very much in its infancy and is starting to work through all the necessary questions and actions that may get the Health Board to the position where they could potentially move towards a scanned patient record. (c) The main issue in terms of current storage arrangements is within the Health Records Service and associated with the acute patient record. Even with four main hospital storage facilities based at each main hospital locality and an offsite storage facility housing over a million patient records there is still not enough capacity available to complete the tasks required on an annual basis to ensure there are appropriate storage arrangements in situ. Storage is the main risk identified on the Health Records and Operations Directorate risk register currently scoring 20. This is also included on the corporate risk register and due to the scoring method is reviewed on a monthly basis. Similar risk may require identification in other services.			
Finding 4 (O) - Retention & Destruction of Records - Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.					
Of the 50 services/ functions/ teams reviewed, 40 retained patient records and information locally. Of the 40 services/ functions/ teams where patient records are retained locally, seven noted that they were unaware how long they are required to keep their records. We also noted that of the 50 services/ functions/ teams reviewed, 27 confirmed the process of archiving/destroying patient documents, nine stated they were unsure/ did not know/	Medium	(a) As identified in the recommendation above following a report reviewed by the non-pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director	The Health Records elements, will be included in a wider action plan for Health Records to be agreed by September 2019 Section (b) of the management response has been completed	Complete

no action taken, whilst 14 did not answer the question.		the scoping working the groups will be required to identify any records outside of retention guidance and the relevant costs of destruction. As clarified above this work will be progressed early in the New Year. (b) In addition to the work that will be carried out by the project groups the approved Retention & Destruction Policy is available to all Health Board staff via the intranet site. The policy is available within the corporate section and provides all staff with clear legal timescales for the retention and destruction of a wide range of records and Health Board information. Staff have the ability to refer to the policy as and when required. To further support retention and destruction processes the Health Records Manager has distributed a global e-mail to all staff notifying them of their individual responsibility to ensure records are only retained for the required period and are destroyed in line with the policy.	of Operations Health Records Manager		
Finding 5 (D) - Access to Health Records Policy - Management should ensure the *Access to Health Records Policy* is reviewed and updated to reflect the introduction of the General Data Protection Regulations.					
The Data Protection Act 1998 was superseded by the General Data Protection Regulations in May 2018. However, the *Access to Health Records Policy has not been amended following the introduction of the new legislation*. Whilst this issue was highlighted by the Information Governance Sub-Committee in their paper submitted to the BPPAC in June 2018, the *Access to Health Records Policy* was not identified for reviewing.	Medium	The Access to Health Records Policy has already been fully reviewed by the Health Records Manager and Information Governance Manager to include all the requirements of the General Data Protection Regulations (GDPR). The information within the policy, such as the payment arrangements have all been update and the policy was distributed across the Health Board for consultation via the global e-mail system earlier this year. No comments or observations were received and the policy is on the agenda for the Information Governance Sub Committee in February 2019 ready for approval.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Health Records Manager	The management response have been completed	Complete The revised Access to Health Records Policy was approved at the July 2019 Information Governance Sub-Committee
Finding 6 (D) - Third Party Storage Providers - Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.					

Six third party storage providers across Wales and England currently retain health records and patient information on behalf of the Health Board. Of the six third party storage providers tested, only three agreements were provided to Internal Audit. The Senior Procurement Business Manager within NWSSP Procurement Department confirmed that they have not been involved in the setup of these agreements between the third party storage providers and the Health Board with some of the agreements setup prior to the formation of NWSSP. A review of these agreements also noted the lack of detail in relation to the security arrangements of Health Board documents retained at the storage facilities.	High	Again as identified in finding 3 and 4 early this year a financial report was presented to the non-pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: • What records/information they have in storage • What are the costs (per box per month/year) • Are there any exit costs • Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director of Operations Health Records Manager	The Health Records elements, will be included in a wider action plan for Health Records to be agreed by September 2019	Complete
Finding 7 (D) - Records Management Training - Management should establish refresher sessions to ensure existing staff receive records management training.					
The Records Management Internal Audit follow up report raised a recommendation that records management training needs assessment should be carried out and rolled out to relevant staff, and consideration should be given to making records management training mandatory. The management response stated that work was still on going and would form part of the routine work of the	Medium	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust	**Lead Director(s)** Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Deputy Director of Operations Health Records Manager	30th September 2019	Complete As part of the Tracking of Patient Records, and the links with the Information Governance Team, basic training will provided to a number of key service areas during the remainder of 2019 and 2020

Head of Health Records along with the Learning and Development function of the Health Board. We were informed by the Health Records Manager that health record training sessions had been undertaken for all secretarial staff and ward clerks across the four acute sites (with the exception of ward clerks at Bronglais Hospital), whilst records management now forms part of the corporate induction for new starters. However, staff currently in post do not receive any refresher training.		departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.			
Finding 8 (O) – Record Management Practices Audits - Management should review the Health Records Management Policy and Health Records Committee terms of reference to reflect the updated Health & Care Standards.					
The content of the Health Records Committee TOR and Health Records Management Policy both make reference to Healthcare Standard 20. However, the Healthcare Standards were superseded by the Health & Care Standards 2015 that does not require regular record management practices audits.	Medium	The Health Records Group TOR has been updated and will be presented to the group for approval in January 2019. The Health Records Management Policy and Health Records Management Strategy have also been updated and will be approved either by a Chair's action from IGSC or at the IGSC meeting in February 2019.	**Lead Director(s)** Director of Planning, Performance, Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director of Operations Health Records Manager	Completed. The Health Records Group has been reformed, and is being chaired by the Assistant Director of Informatics, until a clinical lead can be identified. The Group will report to the Information Governance Sub-Committee (IGSC) as a standing agenda item	Complete.
Finding 9 (O) - Health Records Committee - Management should ensure that the Health Records Committee regularly meet as per the frequency detailed in their terms of reference.					
Testing was undertaken to establish whether record management practices audits had been regularly reported to	Medium	Unfortunately, it has taken longer than expected to re-introduce the Health Records Group within the Health Board, due to the initial inability to identify a clinical lead as	**Lead Director(s)** Director of Planning, Performance,	Completed. The Health Records Group has been reformed, and is being	Complete. The Health Records Group has

the Health Records Committee. However, we were informed by the Health Records Manager that the Health Records Committee had not met during 2018.		Chair. Now that the issue has been resolved the Health Records Group met on the 19th October 2018. The initial meeting was simply to confirm arrangements and work programme for the group moving forward and to ensure the correct individuals were identified as part of the group membership. It was agreed that the group would be fully implemented on a formal basis from January 2019 with meetings conducted on a monthly basis.	Informatics and Commissioning Deputy Chief Executive/ Director of Operations **Lead Officer(s)** Assistant Director of Informatics Deputy Director of Operations Health Records Manager	chaired by the Assistant Director of Informatics, until a clinical lead can be identified. The Group will report to the Information Governance Sub-Committee (IGSC) as a standing agenda item	met twice, and will be concentrating on the improvement plan for Tracking of Patient Records