C.8 Submission to IHRD – Information Governance

1. This paper covers both Records Management and Clinical Coding.

Records Management Controls Assurance – Health & Social Care

2. Until 1996, The Northern Ireland Hospital Authority Circular HMC 75/62 set out the principles for the retention of hospital records.

3. In 1983, DHSSPS Circular HSS (OS3) 1/83 amended Circular HMC75/62 and recommended new minimum periods of retention for personal health records (other than records held by the Central Services Agency). This change was to take account of the provisions of the Limitation (Northern Ireland) Order 1976 and the Congenital Disabilities (Civil Liability) Act 1976. The new minimum retention periods increased the retention of medical records relating to children and young people and those relating to Mentally Disordered Persons.

4. In 1996, Circular HSS(SC) 3/96 was issued which introduced guidance on computerised records, microfilming of records and retention of X-Ray films. It also included a joint position between professional bodies and the Department on the retention of maternity records.

5. In February 2003, following the publication of the Northern Ireland Audit Office Report on Compensation Payments for Clinical Negligence, the Departmental Board agreed the need for a strategic approach to records management in the Health & Personal Social Services (HPSS). The Health and Social Care Steering Group was appointed in 2003, under the leadership of the then Deputy Chief Medical Officer, Dr Ian Carson. The Steering Group's responsibilities included:
   - Commissioning a baseline audit and survey of records management within the HPSS.
   - Developing a HPSS Records Management Policy Statement.
   - Developing a Northern Ireland equivalent of the Department of Health (DoH) "For the Record Circular".

As a result of the work of the Steering Group, a Records Management Controls Assurance Standard was developed, setting out the standard of record keeping required within Health and Social Services.

6. A HPSS Records Management Policy Statement was developed and issued to the HPSS on the 3 November 2004.

7. The Northern Ireland equivalent to the DoH, For the Record Circular, Good Management Good Records (GMGR) was published in December 2004. GMGR provides records management guidance including the recommended minimum retention periods for HSC records. The guidance advised on current best practice in records management and provided organisations with a model disposal schedule for files. It also included advice about the Freedom of Information Act.

8. The Records Management Controls Assurance Standard required HPSS organisations to evidence how they complied with the Standard from April 2004. The Standard sought that "**A systematic and planned approach to the management of <u>all</u> records is in place within the organisation that ensures, from the moment a record is created until its ultimate disposal, that the organisation can control, both the quality and quantity of information it generates; can maintain that information in a manner that effectively services its needs and those of its stakeholders; and it can dispose of the information appropriately when it is no longer required."** It was initially supported by 10 criteria, which were subsequently consolidated into 6 criteria in April 2009.

9. The introduction of the Records Management Controls Assurance Standard set the basis for a systematic and planned approach to the management of all records in HSC organisations, thereby supporting a system of risk management governing both corporate and administrative records. Organisations are required to annually assess themselves against this standard.

10. The Department's Information Management Branch has annually assessed compliance against the standard and in conjunction with representatives from HSC Organisations sought to develop records management.

11. Records Management has continually developed and the Department has led this work, which has included a review of the Good Management Good Records guidance and a

review of the Controls Assurance Standard, as well as considering the need for legislation and the development of Information Sharing Protocols.

12. The review of the Controls Assurance Standard was completed in April 2013 with the focus shifting from purely Records Management to an overarching Information Management Standard, with Records Management remaining a key strand. HSC organisations will be required to report against the new standard in April 2014.

13. The review of Good Management Good Records in 2010-2011 considered the revised Department of Health (DoH) Records Management NHS Code of Practice (2009). It also took account of current legislative requirements, advice from professional bodies and current best practice in relation to records management and the changing environment in relation to electronic records. The experiences of the Department, Health and Social Care Organisations, Public Safety and those working under contract to them were also considered i.e. GPs, Community Pharmacists and Dentists. Where appropriate the opinion of clinicians and professionals was sought. The revised Good Management Good Records was issued in November 2011.

14. The 2011 Good Management Good Records now applies to all records held by the HSC, the Department and Public Safety.

15. A list of guidance documents is attached at Annex A.

Clinical Coding Update September 2013

16. The profile of clinical coding has been raised over the last number of years, due to various factors such as the Commissioning Plan Direction, Priorities for Government, and Indicators of Performance. Previous years' information relating to the management of clinical coding in the mid-late 90's is not available. However, it is possible to provide details on the levels of clinical coding from 1994/95 onwards. These have been presented in the tables below and show the change in coding at five yearly intervals since 1994/95 and also the position of clinical coding relating to the last full financial year, 2012/13.

17. Clinical coding is continually updated during the financial year and it should be noted that DHSSPS Hospital Information Branch close the file once coding has reached a sufficient

level. In recent years, coding levels have increased but so has the length of time taken to achieve these levels.

Table 1: Primary Diagnosis Coding by HSC Trust

HSC Trust	1994/95	1999/00	2004/05	2009/10	2012/13
Belfast	98.0%	99.2%	99.9%	97.1%	98.2%
Northern	99.5%	98.8%	98.4%	98.8%	99.6%
South Eastern	89.1%	93.6%	97.1%	99.7%	99.3%
Southern	98.8%	98.7%	99.5%	98.1%	99.5%
Western	99.1%	99.0%	99.3%	97.9%	99.7%
Total	**97.2%**	**98.2%**	**99.1%**	**98.1%**	**99.1%**

Source: Hospital Inpatient System

18. The number of finished consultant episodes (FCEs) recorded without a primary diagnosis has decreased from 11,555 in 1994/95 to 6,258 in 2012/13. This has been achieved despite the number of FCEs recorded on the Patient Administrative System (PAS) increasing by 65.7% from 407,790 in 1994/95 to 675,858 in 2012/13.

19. Within the Department clinical coding levels are monitored monthly at HSC Trust, hospital and specialty level. This is due to the fact that coding at HSC Trust level can mask specific areas of poor clinical coding in particular hospitals/specialties. Areas where coding levels fall below expected levels are highlighted in the monthly Departmental Board report.

Table 2: Average Diagnosis Coding Depth by HSC Trust

HSC Trust	1994/95	1999/00	2004/05	2009/10	2012/13
Belfast	1.4	1.5	1.8	2.9	3.3
Northern	1.5	2.2	2.4	2.5	4.2
South Eastern	1.7	2.0	2.8	2.9	4.6
Southern	1.5	1.9	2.1	2.9	4.6
Western	1.4	1.5	1.9	2.3	3.1
Total	**1.5**	**1.7**	**2.1**	**2.7**	**3.8**

Source: Hospital Inpatient System

20. Since 1994/95, the quality and depth of clinical coding has increased steadily over the years. This is reflected in Table 2 where the average number of diagnosis codes for each episode has increased from 1.5 in 1994/95 to 3.8 in 2012/13. This shows that more detailed information regarding the patient's condition and co-morbidities is now being captured.

Historical Activity

21. The Regional Clinical Coding Team was under the management of the Directorate of Information Systems/Business Services Organisation from 2000 until June 2010, when management moved to the Performance Management and Service Improvement Directorate in the Health and Social Care Board.

22. In August 2011, the HSC Board commissioned a broad based clinical coding audit to obtain a clearer picture of the quality of clinical coding and of any issues around the production of accurate and timely clinical coded data. These audits recommended the need for further specific areas of audit including orthopaedic, palliative care, maternity, paediatrics/neonatal and mental health. This programme has since commenced and further details are given in Annex B.

Performance Monitoring

23. The HSC Board currently has responsibility for regional consistency of clinical coding across HSC Trusts to ensure that improvements in clinical coding standards are achieved and maintained to a high standard. Additional recurrent and non-recurrent funding has been made available to Trusts to help raise clinical coding levels over the last three years.

24. The Regional Information Group (RIG), chaired by the Department, has oversight of data standards, clinical coding and the audit sub group which is chaired by the HSC Board. Clinical coding continues to be monitored formally by RIG, Senior Departmental Management and is also discussed at all Department accountability meetings with the HSC Board and Trusts.

25. Clinical coding standards established by the HSC Board and the Department for the last three years are detailed below.

2011/12 Coding Standards

26. To improve the standards of clinical coding and increase the quality and timeliness of data in 2011/12, the HSC Board introduced a requirement to have all clinical coding for 2011/12 activity coded and recorded on PAS by 30th June 2012. It was also required that the depth of coding should reach an average >3.5 diagnoses per episode of care across all specialties and all hospitals.

2012/13 Coding Standards

27. Following meetings with the Department, the HSC Board again issued standards in relation to the clinical coding of 2012/13 activity data to HSC Trusts as follows:

- Activity carried out in the first six months of 2012/13 year to be coded and recorded on PAS within 3 months of discharge;
- Activity carried out in the last 6 months of 2012/13 to be coded and recorded on PAS within 2 months of discharge.

28. Similarly the depth of coding was to be maintained at an average of >3.5 diagnosis per episode across all Trusts.

2013/14 Coding Standards

29. Again after consultation with the Department, the HSC Board issued a letter in relation to standards and timescales for clinical coding on the 31st July 2013, stating that:

- At least 98% of hospital inpatient/day case activity (including on-site Independent Sector activity) carried out in the first 6 months of 2013/14 year to be coded and recorded on PAS within 3 months of discharge on a rolling basis;
- At least 98% of hospital inpatient/day case activity (including on-site Independent Sector activity) to be coded and recorded on PAS within 2 months of discharge on a rolling basis; and,
- All 2013/14 hospital inpatient/day case activity (including on-site Independent Sector activity) to be coded and recorded on PAS by 31 May 2014.

Annex A

Records Management Guidance Documents

Folder Tab	Reference/Number	Content
A	Circular H.M.C. 75/62	Preservation and Destruction of Hospital Service Records. This Circular was issued by the Northern Ireland Hospitals Authority and sets out arrangements for the preservation and disposal of hospital service records.
B	DHSSPS Circular HSS (OS3) 1/83	Retention of Personal Health Records - This Circular amends (but does not cancel) Circular HMC75/62 and recommends new minimum periods of retention for personal health records (other than records held by the Central Services Agency) to take account of the provisions of the Limitation (Northern Ireland) Order 1976 and the Congenital Disabilities (Civil Liability) Act 1976.
C	HSSE (SC)3/96	Retention of Personal Health Records (for possible use in Litigation) – This Circular updates guidance in Circular HSS(OSC)1/83 and HMC75/62: • Recommends new minimum periods of retention for maternity records and x-ray film; • Allows Boards/HSS Trusts to determine what should be regarded as a permanent health record; and • Provides new guidance on the destruction of confidential health records. It does not apply to records held by the Central Services Agency.
D	Good Management, Good Records -	These guidelines offer an overview of the key issues and solutions, and best practice for HPSS teams to

	Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland (2004)	follow when preparing a records management strategy. It sets out the minimum retention periods for HPSS records of all types, except for GP medical records, and indicates which records are most likely to be appropriate for permanent preservation.
E	Good Management, Good Records - Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland (2011)	A guide to the required standards of practice in the management of records for the DHPSS. It replaced Good Management Good Records 2004, Circular HSS (PCCD)1/2000 – Preservation, Retention and Destruction of GP Medical Records and Circular HSS(F) 14/03 – Preservation and Destruction of Financial and Associated Records.
F	Records Management Controls Assurance Standard 2004	Organisations were required to annually assess themselves against this Records Management Controls Assurance Standard.
G	Records Management Controls Assurance Standard 2009	Organisations were required to annually assess themselves against this Records Management Controls Assurance Standard.
H	Information Management Controls Assurance Standard 2013	Organisations will be required to assess themselves against this Records Management Controls Assurance Standard from April 2013.

HSCB Clinical Coding Standards Team Audit Schedule 2013-2014 **Annex B**

Audit	Objective	Timescale for Audit	Timescale for Final Audit Reports to be Available
Palliative Care Review Audit	To identify any systemic issues in the accurate clinical coding of Palliative Care cases and to assess implementation of previous audit recommendations	March – June 2013	September 2013
Maternity Audit	To identify any systemic issues in the accurate clinical coding of Maternity-related activity and to recommend remedial action.	Completed	August 2013
Termination Of Pregnancy Audit	To produce robust, timely statistics on ToPs in 12/13 and to identify any systemic issues in the accurate clinical coding of ToP cases and to recommend remedial action	July – August 2013	Figures available September 2013 Reports available October 2013
Trauma and Orthopaedic Audit	To identify any systemic issues in the accurate clinical coding of Orthopaedic activity and to recommend remedial action	Completed	September 2013
Paediatric and Neonatal Audit	To identify any systemic issues in the accurate clinical coding of Paediatric and Neonatal activity and to recommend remedial action.	September – November 2013	February 2014
Mental Health Audit	To identify any systemic issues in the accurate clinical coding of Mental Health-related activity and to recommend remedial action.	January – March 2014	June 2014