Royal Devon University Healthcare NHS Foundation Trust

Title: Medical Records Policy & Procedures / Job Descriptions

Reference Number: RDF1233-23
Date of Response: 01/03/23

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

The Royal Devon is in the processing of integrating departments, structures, job descriptions, policies and procedures and so most of the information you have requested is not yet available for the Royal Devon. We have provided copies of legacy information where relevant for our Northern and Eastern services however please be aware that they are subject to change as the internal integration work continues.

I am requesting the following information in electronic format:

1. *medical records policy and procedure documents (covering management of the Epic EHR, medical record corrections, duplicate medical records, incorrect demographics).*

   Please find attached:
   - Standard Operating Procedure for Northern Services for scanning and importing paper documentation to Epic.

   Please find attached the current legacy documentation that are in the process of being reviewed following the integration and therefore subject to change.
   - Q1. Health Records Policy (East)
   - Q1. Healthcare Records Policy (North)
   - Q1. Records Management Policy (East)

2. *approved medical abbreviations policy / procedure / guideline / protocol*
   The Trust does not hold an 'approved medical abbreviations' documentation.

3. *job descriptions and AfC banding for medical records personnel (all levels including manager / head of / director or department)*
   Please see job descriptions attached for the following roles:
   - JD Band 6 – Digital Healthcare Records Manager (Northern)
   - JD Band 5 - Assistant Digital Healthcare Records Manager (Northern)
   - JD Band 4 – Digital Records Team Leader (Northern)
   - JD Band 3 - Digital Records Officer (Northern)
   - JD Band 6 – Health Records Administrative Services Manager (Eastern)
   - JD Band 5 – Health Records Administrative Line Manager (Eastern)
   - JD Band 4 - Health Records Supervisor (Eastern)

- JD Band 2 – Administration Assistance (Eastern)
- JD Band 2 - Health Records Admin Assistant & Driver (Eastern)

4. *job descriptions and AfC banding for data quality personnel (all levels including manager / head of / director of department)*
   Please see job descriptions attached for the following roles:
   - JD Band 8a - Programme Manager Data Quality (Eastern)
   - JD Band 7 - Senior Clinical Application Analyst Data Quality (Eastern)
   - JD Band 6 - Clinical Application Analyst Data Quality (Eastern)
   - JD Band 4 - Data Quality Lead (Eastern)
   - JD Band 3 – Clinical Application Support Assistant Data Quality (Eastern)
   - JD Band 4 – Data Quality Officer (Northern)
   - JD Band 7 - Information Systems & Data Quality Manager (Northern)

5. *job descriptions and AfC banding for staff who deal with releasing patient medical records / DSAR.*
   Please see job descriptions attached for the following roles:
   - JD Band 4 – Information Governance Officer (Eastern)
   - JD Band 3 – Information Governance Support (Eastern)
   - JD Band 4 – Healthcare Access to Records Supervisor (Northern)
   - JD Band 3 – HCR Access to Records Officer (Northern)

6. *structure of the medical records / electronic health records department*
   Please note that the Health Records structure will be under review following the integration. Please see attached documents for the separate services currently and subject to change:
   - Health Records Department Structure (Eastern)
   - Digital Healthcare Service Departmental Structure (Northern)

7. *structure of the clinical coding department*
   The Clinical Coding Department Structure is currently under review as part of the integration therefore cannot be provided at this time.

8. *clinical coding policy and procedure documents (including training and audit)*
   Please see link below to the Clinical Coding Policy and Procedures documentation currently, and note the documentation is in the process of being reviewed as part of the integration and subject to change.

   https://www.northdevonhealth.nhs.uk/wp-content/uploads/2017/12/Clinical-Coding-Policy-and-Procedures.pdf

Royal Devon University Healthcare
NHS Foundation Trust

Document Control

Title	**Epic Day Forward Scanning Standard Operating Procedure**		
Authors [redacted]		**Author's job title** **Digital Records Manager**	
Directorate Digital Services		**Department** HealthCare Records	**Team/Specialty**

Version	Date Issued	Status	Comment / Changes / Approval
0.1	June 2022	Draft	Initial version for consultation
0.2	August 2022	Draft	Amendments taking into account experience post Epic go live

Main Contact **Digital Records Manager** North Devon District Hospital Raleigh Park, Barnstaple, EX31 4JB	**Email** [redacted]
Lead Director Chief Information Officer	
Document Class Standard Operating Procedure	**Target Audience** All Staff
Distribution List Senior Management	**Distribution Method** Trust's internal website
Superseded Documents Community Services Standard Operating Procedure for an Electronic Health Record	

Issue Date	**Review Date**	**Review Cycle** Yearly

Reviewed & approved by:	**Contact responsible for implementation and monitoring compliance:** Healthcare Records Manager
	Education/training will be provided by:
Local Archive Reference **Local Path** **Filename**	

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
Policies & SOPs	Epic; Scanning; Documents; Records; HealthCare Records
Any revision to an NHSLA document requires the agreement of the Senior Governance Manager (Compliance)	

1. Introduction

This standard operating procedure (SOP) has been developed to support the day forward scanning of required clinical paper documentation into Epic.

It is important for maintaining the integrity of our patient records that scanning of information is managed properly and in line with appropriate policies, guidelines and procedures including, but not limited to;

- NHSX Records Management Code of Practice 2021
- Community Paper Documentation Post My Care SOP Final 1.1
- Medical Records Policy
- How to guide: How to scan paper documents into Epic via MFD/file import – Importing • How to guide: How to scan paper documents into Epic via desktop scanner - Scanning

2. Purpose

This SOP has been written to help maintain the integrity of our patient record by ensuring the

- quality of digitised documentation
- standardisation of digitised documentation
- timeliness of digitised documentation
- validity of digitised documentation

3. Digitised Paper Documentation

The most common and acceptable way to digitise a physical document is to scan it.

Documentation must not be photographed in order to digitise it. This includes using the Haiku app. It is very difficult to control the quality of the digitisation, for example;

- to ensure there is no other objects, papers etc in the background of a photo
- to ensure that the image is straight
- the image includes the entirety of a page or the entirety of the document
- it is very easy to not include the reverse side of a document

When a document is digitised and added to the patient record, it becomes subject to quality assurance processes that the Trust is required to follow. Quality assurance includes;

- Quality of the scan/digitisation
- Clear identification of the document in the image
- Checking and audit processes
- 90-day retention of original document prior to destruction

4. Scope

What is in the scope of this document

- This SOP relates to all staff who have access to Epic.
- This document covers the process of digitising physical paper documentation to a patient record in Epic

What is not in the scope of this document

- The importing of digital communication is not included in the quality assurance process and is therefore excluded from this SOP
- Digital communication is any communication or documentation that originates in or is provided to us by electronic means
- Examples of digital communication ○ Emails, and letters/referrals sent via email
    - Reports generated by other systems interfaced with Epic – eg Lab reports, CRIS reports, ECG reports
    - Letters produced by M-Model
    - Photos taken of wounds and directly loaded to Epic
- These communications should remain digital. They should not be printed; any annotation required should be done using workflow in Epic
- If digital communication is printed, it is then subject to the quality assurance processes for paper documentation requiring scanning.
- Digital communication **does not** include taking photographs/images of paper documentation and importing these to Epic

5. Responsibilities and Duties

The Trust has a duty of care to ensure that all aspects of records management are properly managed. The Trust is subject to several legal, statutory and good practice guidance requirements, covering healthcare records.

- The Chief Executive has overall accountability and responsibility for Records Management within the trust.
- The Information Governance Manager will provide advice and guidance on the handling of records and information.
- The Healthcare Records manager is responsible for ensuring all Healthcare Records staff carry out scanning of clinical information in line with the guidance of this policy.
- All staff are responsible for ensuring they follow guidance laid out in this document when scanning into a patient record.

As outlined in the NHS Code of Practice, failure to properly maintain digital records can result in doubt being raised over the authenticity of the digital image. Digital information presents a unique set of issues which must be considered and overcome to ensure that records

- Remain authentic
- Remain reliable
- Retain their integrity
- Retain usability

In the context of this SOP, we are addressing authenticity and reliability. Integrity and usability of records are addressed in the Healthcare Records Policy.

Clinical staff; whether using the central scanning bureau or otherwise, are responsible for ensuring that documentation is

- fit to be scanned
- clearly labelled with patient identifiers
- genuinely required to be scanned

6. Principles

The Epic system is expected to deliver

- Contemporaneous record keeping
- A live / shared system accessible across disciplines, professions and services
- Improved and appropriate access to information
- Support mechanisms for improved patient safety
- A reduction of duplication for patients and services
- Maximisation of staff time
- Improved information reporting

The default position regarding scanning into Epic, is that scanning is NOT required, the expectation is that all clinical documentation takes place electronically.

However, it is accepted that it will not be possible for all documentation to be electronic, and a limited range of paper documentation will be retained. In order to ensure the above overall benefits are realised changes to our records management are required.

It is intended that where practically possible Northern Services will take a centralised approach to scanning documentation into the Epic record. This will be managed, and for the most part carried out by, the Healthcare Records department.

7. Assumptions

A number of assumptions have been made in producing this document and are outlined here. These can be addressed and corrected as necessary through later iterations of this document
This is a new process, and we cannot have a full understanding of how well the process will work. We have assumed;

- Reasonable volumes of paper documentation will be presented to the department for scanning, but it is unclear what constitutes 'reasonable'

  Volumes of documentation will be monitored, and reviewed with clinicians on a regular basis until such time as we have settled into a pattern

- Clinicians will be responsible for deciding the right reasonable time to enter documentation into the scanning process

- Areas which are unable to access the central scanning facility due to location will have access to scanners

- Any documentation that is received into the Trust via electronic means, eg email, will not be printed to hard copy, but will be imported to Epic by the recipient

- Paper documentation produced as a result of any business continuity process will not be included automatically in the central scanning facility, but should be managed within the Business Continuity Plan

8. Centralised Scanning

Any paper documentation required following the go live of Epic, will be scanned into Epic centrally by the Healthcare Records department scanning bureau.

This means that where we can manage the timely collation and transportation of documentation to the Healthcare Records department at NDDH, it will be scanned by them under SLA as detailed below.

Exceptions to this standard are outlined below.

Areas eligible for in-house scanning

In line with current delivery and collection locations and timelines, any documentation to be scanned for any service provided by the Trust from the following locations: • All NDDH activity; including that not previously managed by HCR

- Barnstaple Health Centre
- South Molton Hospital
- Holsworthy Hospital
- Stratton Hospital
- Torrington Hospital
- Bideford Hospital
- Ilfracombe Hospital

Exceptions to in-house scanning

Where we are not able to accommodate the collection of paper due to location – ie sites not on current delivery/collection routes, or because of the nature of the service, scanning will be managed within the relevant location/department. The following fall into this category:

- ED
- CMC
- Bladder & Bowel Service
- Podiatry
- Health and Social Care Teams
- Tiverton Hospital
- Non-Trust sites ○ GP Practices

Service Level Agreement

For those locations/services that fall into the central scanning remit, the Healthcare Records department undertake

- To collect documents
  There will be designated, identifiable collection locations at the above sites, with; ○ 2 daily pick-ups on weekdays & 1 pick-up at weekends at locations around NDDH ○ 1 daily pick-up on weekdays at community sites
- For documentation received into the department by 17:00 it will be scanned into Epic within 48 hours
- Urgent requests can be made

Services supported by the scanning bureau will undertake to

- Complete the coversheet provided for each piece of documentation sent for scanning ○ to ensure HCR receive sufficient information to scan the document to the correct location
  - ○ to provide reason for the document to be scanned; examples
    - ✦ not Epic workflow
    - ✦ third party document – eg letter received from gp, patient, another Trust ○ to form part of our audit process

- Ensure all documentation is clearly identifiable to the patient ○ use a patient label if necessary

- this is required so that when the record is viewed once scanned, there can be no question as to that image being associated with that patient – ensuring our record is authentic and reliable

HCR will provide an urgent scanning service if information is required in the system sooner than the 48 hours. These items should be brought to the department, not put in the collection trays.

If HealthCare Records are required to follow up on documentation due to

- insufficient/incorrect patient information
- missing pages
- poor document quality there may be a delay in scanning while necessary checks are carried out

9. Legitimate Paper Documentation

To maintain the integrity, consistency and reliability of our patient record we should define here what paper documentation should be scanned.

What should be sent to HealthCare Records

- Any supporting documentation to electronic workflow processes that are not scanned as part of the process
  For example ○ Referrals made to outside providers (eg. PET scans)
- Miscellaneous paperwork that does not exist in the system
- External organisational documentation sent in paper format relating to a patient record
  For example ○ Letters sent from GP's **by post** (not email)
  ○ Transfer documentation from another Trust, that arrive with the patient ○ CAMHS assessments completed on the ward

What should **not** be sent to HealthCare Records

- Electronic documentation that can be electronically imported (where team workflows allow)
  For example ○ Emailed letters
- Print outs from electronic systems (especially print outs of Epic screens and systems interfaced to Epic)
  For example ○ ECG's ○ Lab reports ○ CRIS reports ○ M-Model Letters
- Referral's – these should be scanned into the system as part of the referral pathway process and therefore are not to be sent to HealthCare Records
- Any paperwork that requires 'action' such as orders or requests – these should be done electronically in the system and only supporting reference sheets should be sent to HealthCare Records for scanning

10. Process

On Receipt of documents to be scanned a. Sorting/Verifying Documents

- Ensure the document is post Epic Go-Live (09/07/2022)

- Ensure the document has not originally been printed from Epic – you do not need copies of the same document in the system. **The only exception to this is if the document has been annotated with information that is not otherwise in Epic since printing.**
- Ensure the document is a legitimate paper document ○ Investigate with originator why they've done this in paper
    - ✦ New/uncommon document
    - ✦ If the information should be in clinical noting in Epic, the originator should add the information to Epic, and the document should not be scanned
  - ○ If this is a new or uncommon document
    - ✦ Scan the document
    - ✦ Ensure supervisor has a note of the document so we can understand frequency/requirement, and make amendments if necessary
- Remove referral letters – these will have been scanned into Epic by CMC during the referral process
- Prioritise urgent requests ○ Inpatient direct admissions e.g. GP referrals, ambulance admissions
  - ○ Urgent outpatient appointments
  - ○ these will be similar to current urgent requests for notes

b. Preparation for scanning

- Have you been provided with enough accurate information to identify and locate the patient in Epic?
- Is the document in a condition to be scanned?
  - ○ If the document has multiple pages – can you verify they are all there?
  - ○ Check the quality of the original document – is it clear enough to be scanned? Consult with manager/clinician to determine whether the document is fit to be kept

  Contact the originator to clarify the condition of documents; missing pages are correct and annotate the document prior to scanning to show the pages supplied
- Identify document type and level, ie Patient, Encounter, Order ○ Patient – Attached to whole patient
  - ○ Encounter – Attached to specific admission, visit, appointment etc ○ Order – attached to a specific test, request, order

c. Scanning

- Find the patient in Epic ○ Do the details provided match – tick those that match ○ If you are unsure of the match – escalate to supervisor/manager ○ Add your initials to the document
- Confirm that duplex and colour settings are correct for the document on the scanner, and scan the document
- Check the quality of the scan ○ Readable ○ All pages present ○ Correct orientation/rotation
- Save the document
- Place document ready for Quality Assurance checking

d. Special Documents

- Power of Attorney
- Advanced Directives
- Living Wills ○ Documents must be an annotated copy, not the original document ○ Documents to be reviewed by supervisor prior to scanning ○ Scanned by anyone

Scanning Process a. PC has connection to Desktop Scanner

If your PC is connected to; or has a connection with a desktop scanner you will be able to scan a document and attach directly to Epic following these steps:

- See How To Guide: How to scan paper documents into Epic via desktop scanner

1. Login to Epic Hyperspace
2. Open the Media Manager tool
3. Enter the patient MRN (record number) and click Find Patient
4. Check patient details ensure you have the correct patient and click Select
5. Select the correct Encounter Level – Patient, Encounter or Order
6. Click the Scan button
7. Place your document correctly in/on the scanner
8. If the document is double sided – select the Duplex option on the right-hand side of the screen
9. Click Acquire in Epic

When documents have scanned

10. Enter an appropriate document description (see below)
11. Add the correct document type
12. When you are happy all information is correct, Click Save Doc
13. Forward the hardcopy paper to Healthcare Records marked 'Quality Assurance'

Document description

To ensure documentation is readily identifiable once scanned or imported we need to provide a consistent description for documents; this should be based on

- Who/where the document has originated from; and
- The date of the original document

For example; a letter from Musgrove Park Hospital, Rheumatology Department, dated 01/07/2022 would be named:
Somerset NHS Foundation Trust Rheumatology 01072022

b. Access to MFD (multi-functional device) or another scanner

If you have access to an MFD printer or another scanner type, you will be able to scan the document and email it to yourself.

- See How To Guide : How to scan paper documents into Epic via MFD/file import (importing)

To mitigate Information Governance risks, follow these processes carefully as they will help reduce the risk of confusing patients and documents

- Scan individual patients documents separately; and subsequently
- Email individual patients documents separately
- Fully complete the steps for each individual patient before starting the next

The process to upload a document to Epic

1. Select the email to work on
2. Open the scanned attachment
3. Select File / Save As
4. Save to your departments shared drive
5. Complete File Name
    - **Patient Surname, DOB and MRN**
6. Upload to patient record in Epic
    a. Login to Epic Hyperspace

b. Open the Media Manager tool
c. Enter the patient MRN (record number) and click Find Patient
d. Check patient details ensure you have the correct patient and click Select
e. Select the correct Encounter Level – Patient, Encounter or Order
f. Click the Import button
g. Navigate through your file drives to the correct document
h. Enter an appropriate document description (see below)
i. Add the correct document type
j. When you are happy all information is correct, Click Save Doc

7. Delete the scan from the Drive – this is most important for Governance compliance
8. Forward the hardcopy paper to Healthcare Records marked 'Quality Assurance'

Document description

To ensure documentation is readily identifiable once scanned or imported we need to provide a consistent description for documents; this should be based on

- Who/where the document has originated from; and
- The date of the original document

For example; a letter from Musgrove Park Hospital, Rheumatology Department, dated 01/07/2022 would be named:

Somerset NHS Foundation Trust Rheumatology 01072022

c. Quality Assurance & the 90 Day Retention Process

We are required not only by the NHSX Records Management Code of Practice 2021, but also by international and British standards (ISO270001, ISO9001 & BS10008) to retain any document that has been scanned for a period of at least 90 days before it can be destroyed.

For the Trust to meet its obligations for information management, we must adhere to Quality Assurance guidelines to ensure that our scanned documentation maintains its authenticity and integrity, and that we are able to provide evidence of the quality, trustworthiness and confidentiality of our electronic information.

In order to meet quality standards, all documentation that is digitised must be

- Identifiable to the patient ○ if the document does not have patient identifiers in its content, use a patient label
- Whole
  - the front and back sides of all documentation must be scanned
  - the complete document should be scanned, where pages are missing, an explanation must be provided
  - the full page, corners must not be bent over/dog eared, the edges of the page should be visible
- Original ○ where possible, original documents should be provided for scanning
- Of good scanned quality ○ documentation must be scanned in the correct order; ie page 1, 2, 3 etc ○ documentation must be up the right way; ie not upside down, on its side, or skewed ○ documentation must be clear; ie not smudged, faded, blotted etc

These standards apply to all documents that are scanned, regardless of where and by whom they have been scanned. Any documentation that does not meet these standards will be required to be rescanned.

- ALL our scanned documents will go through a Quality Assurance process, carried out by the quality assurance team in HealthCare Records department.

- The process will be reviewed at regular intervals to monitor our requirements.

- Documents that are scanned outside of the central scanning unit process also require to be retained for 90 days and quality assured. **Please ensure that these hardcopies are forwarded to the Healthcare Records department, marked 'Quality Assurance'**

- Once scanning has been quality assured, and the 90-day retention period has been met, most documentation will be destroyed, through normal Trust processes.

- The 90 day retention policy does not apply to documents that have been received and imported to Epic via email. Please do not print electronic documents, these can be imported directly to Epic.

11. Appendix

a. All Document Types, by Levels

i. Document Types for Patient Level

Advance Decision to Refuse Treatment	Advance Decisions and Living Will	Care Everywhere Prospective Authorization	Case Management Attachment
CE Auth Form (Scanned)	CHC/Fasttrack Form	Clinical Photograph - Clinical & Teaching Consent	Clinical Photograph - Clinical Consent Only
Clinical Photograph - Clinical, Teaching & Publication Consent	Clinical Photography Consent	Communication Sheet	Community Lab Referral Form
Community Upload	Consent Form	CORE Group paperwork / MDT	CYPACP
Death Certificate	Death Summary	Disability Form	DNR (Do Not Resuscitate)
Downtime Documentation Forms	DPT Documentation	Durable Medical Equipment	Emancipated Minor
Emergency Healthcare Plans	End of Care Documents	Face Sheet Capture	Fertility Consent
GP Letter	GP Note	GP Other Document	HIM Release Restriction
HIM ROI Authorisation	Hospice Election	International Pt. Documents	Lasting Power of Attorney for Financial Decisions
Lasting Power of Attorney for Healthcare Decisions	Legal Guardianship	Letter	Manual Handling Plan
Medication Removal / Destruction Form	MyChart and MyChart Bedside Proxy Consent	Newborn Identification Form	Notice of Privacy Practice

Patient Entered Attachment	Patient Image	Patient Letter	Patient Photo
Photo ID	Planning for Your Future Care	Power of Attorney	Pregnancy Prevention Programme
Prescription	Prescription Dispense Prep Image	Prescription Insurance Card	Prospective Auth
Provider Attachment	Provider Letter	Referral Attachment	Referral Form
Release of Information	Residential Care Plan	Stem Cell Transplant	Study Attachment
Third Party Letter	This is me	Treatment Escalation Plan (TEP)	

ii. Document Types for Encounter Level

9 Panel Plot	Advance Decision to Refuse Treatment	After Visit Summary	Amniocentesis and chorionic villus sampling consent
Anaesthesia Record	Annotation	Antenatal screening choices	ARIA Treatment Summaries
Audiology Report	Autopsy Report	Blister Pack Request Form	Blood Administration Consent
Bone Scan	Cancer Registry	Cancer Staging	CanRisk Assessment
Care Plan	Case Management Attachment	Chemocare Treatment Summaries	Chemotherapy Consent
Chemotherapy Roadmap	Child Health Alliance	Chronic Care Management Consent	Claris Cardiology
Clinical Note Import	Clinical Photograph - Clinical & Teaching Consent	Clinical Photograph - Clinical Consent Only	Clinical Photograph - Clinical, Teaching & Publication Consent
Clinical Photography Consent	Colonoscopy	Community Lab Referral Form	Community Upload
Consent Form	Consent HIV	Consult Letter	Consultation Reports/Note
CORE Group paperwork / MDT	CPAP Therapy	CYPACP	Death Summary
Delivery Summary - Scan	Dental Baseline	Dental Perio Chart	Dental Tooth Chart
Derm Clinical Image	Detailed Notice of Discharge	Discharge Instruction	Discharge Summary
Downtime Documentation Forms	DPT Documentation	Durable Medical Equipment	Emergency Healthcare Plans
Endoscopy Image	Environmental AX	Environmental Images	External email
External Medication Information Consent	Genetic Report	Genetic Testing	Glaucoma Clinic

Glaucoma Clinic Visual Fields	GP Note	GP Other Document	Growth Chart
HealthEdge	HH & Hospice Team Member In Home Verification	HH Plan of Care Update Message	HIM Release Restriction
Holter Monitor	Home Care Medication Reminder Chart	Home Enteral Feeding	Huntleigh CTG
Intake and Output Record	IP self-discharge	Kanta PikaXML CHF	Labour & Delivery Summary
Letter	Loan Form for AAC Equipment from DILIS	Manual Handling Plan	MAR CHART
Medical termination of pregnancy	Medication Administration Record	Mental Health Act	MobiMed Ambulance Run Sheet
MyChart and MyChart Bedside Proxy Consent	Nursing Home Admission	OB Record	Occupational Therapy Plan of Care
Ophthalmology tests	Organ Retrieval Procurement Documentation	Outcome Measures	Outside Record
Oximetry/Capnography Results	Paper / Electronic Prescription (NonEPIC)	Parental responsibility agreement	Pathology
Patient Care Conference	Patient Drawings for Assessments	Patient Education	Patient Letter
Patient videos (Gait and positional)	Patient-Created Audio	Patient-Created Image	Patient-Created Text
Patient-Created Video	Physical Therapy Plan of Care	Physio Tools PDF	Plan of Care E-Sig Form
Plan of Care Snapshot	Planning for Your Future Care	Pregnancy immunisation consent	Prenatal Flowsheet
Prescription Dispense Prep Image	Procedure Consent	Procedure Consent - Blood Component Refusal	Procedure Consent - Parental Agreement
Procedure Consent - Unable To Consent	Prov Comm E-Letter PDF	Provider Attachment	Provider Letter
Psychology Assessment	Questionnaire	RDE Patient to Nuffield	Referral Attachment
Referral Form	Research Case Report Form	Residential Care Plan	Risk to Inform Surgical Choices (RISC)
Safeguarding Meeting Minutes	Safeguarding Referral Form	Sent via Secure Chat	Sleep Observation/Consent Forms/ESS Forms
Sleep Study	Speech Language Pathology Plan of Care	Splinting Photography	Stem Cell Transplant
Study Attachment	Summary of Care	Surgeon Sketch Diagram	Surgical termination of pregnancy

Telemetry Record	Theatre Stack Images	Treatment Escalation Plan (TEP)	Treatment Plan Agreement
Vaccine Information Statement	Welfare of Child	Wound Image - Clinical & Teaching Consent	Wound Image - Clinical Use Only
Wound Image - Clinical, Teaching & Publication Consent			

iii. Types for Order Level

9 Panel Plot	Advance Decision to Refuse Treatment	Alliance Scans (PET Scans)	Ambulatory Monitoring
ARIA Treatment Summaries	Auto-filled Result Image	Capsule Endoscopy	Cardiac Cath Report
CardioCall	Case Management Attachment	CAT Scan	CHC/Fasttrack Form
Communication Sheet	Community Lab Referral Form	Community Upload	CORE Group paperwork / MDT
CPAP Therapy	CRIS REPORT	CT Scan	CYPACP
Cytology Report	Death Summary	Devices Check	Downtime Documentation Forms
DPT Documentation	Durable Medical Equipment	ECG	ECHO
EKG	Emergency Healthcare Plans	Exercise Test	GI Investigations Reports
GP Letter	GP Note	GP Other Document	HIM Release Restriction
Holter	Holter Diary	Home Monitoring Device Check	Imaging Order
Lab Requisition Scan	Lab Result Scan	Letter	Mammogram
Manual Handling Plan	Molecular Genetics Results	MRI	Neurophysiology Report
OB Record	Order Result	Outcome Measures	Outside Order
Outside Record	Oximetry/Capnography Results	Paper / Electronic Prescription (NonEPIC)	Patient Drawings for Assessments
Patient Letter	Physician Order	Planning for Your Future Care	Prescription
Prescription Dispense Prep Image	Provider Attachment	Provider Letter	Pulmonary Function Test
Referral Attachment	Referral Form	Residential Care Plan	Sleep Observation/Consent Forms/ESS Forms
Sleep Study	Spirometry	Stress Test	Study Attachment Third Party Letter

TB Skin Test	Treatment Escalation Plan (TEP)	Ultrasound	Urology Investigations Report

Cover Sheet for Paper Documents sent to HealthCare Records

Please ensure all activity in relation to the document has been completed prior to sending to HCR

Please complete for any documentation being sent to HealthCare Records department

Patient Label		
Date		
Speciality	Clinician Name	
Select as appropriate		
Scanning ☐	Quality Assurance ☐	Destruction ☐
Reason for Scanning ☐ Third Party Document ☐ Not Epic Workflow		

HCR Scanning Bureau Use only

Date received	Document Level
Document Type	Document Description
Scanned by	Scanned date
Delay reason (if any)	
Quality Assurance & Retention Status	
QA Complete	QA not done
Pass	Re-scan

Retain until	Destroyed on

Royal Devon and Exeter NHS Foundation Trust

Health Records Policy

Post holder responsible for Procedural Document	[redacted], Head of Records Management
Author of Policy/Strategy	[redacted], Head of Records Management
Division/ Department responsible for Procedural Document	IMT/Health Records Department
Contact details	Ext: [redacted]
Date of original document	December 1991
Impact Assessment performed	**Yes**
Ratifying body and date ratified	Information Governance Steering Group- 19 May 2020
Review date	September 2021
Expiry date	December 2021
Date document becomes live	9 September 2020

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation**:**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Controlled document

Royal Devon and Exeter NHS Foundation Trust

Version	Date	Author	Reason
1.0	Nov 2007	Information Governance Manager	Health Records Policy updated November 2007 is the first for which there are records
2.0	Nov 2009	Health Records & Information Governance Manager	Health Records Policy updated
3.0	Nov 2009	Health Records & Information Governance Manager & Governance Manager	Standards for record Keeping in Health Records Policy updated
4.0	03/01/2013	Health Records Manager	Standards for Record Keeping Policy has been amalgamated into the Health Records Policy
5.0	13/12/2013	Health Records Manager	Revised to incorporate BS10008 and eNotes
6.0	09/03/15	Health Records Manager	Update to links in section 21
7.0	22/01/2016	Patient Records Manager	General update. Restructuring of document. Incorporating of previous appendices – Trustwide procedure notices
8.0	25/09/2016	Patient Records Manager	Update. Amendment to section 3.4 (Contents of Multi-volume Casenotes); rewording of 5.3.5, link updates
9.0	29/11/2018	Patient Records Manager	Update. Amendment to section 3.4, 3.4.1 (Contents of Multi-volume Casenotes)
10.0	21/09/2019	Head of Records Management	General update to include Data Protection 2018 and job title change from Patient Records Manager to Head of Records Management.
10.1	19/05/2020	Head of Records Management	updating referenced legislation and job title

Associated Trust Policies/ Procedural documents:	Data Protection Policy Data Quality Policy Records Management Policy Information Security Policy Access Policy
Key Words	Health Records, casenotes, Data Protection, storage, retention, destruction, tracer, standards, filing
In consultation with and date: Information Governance Steering Group- 19 May 2020 Quality Assurance- 3 July 2020	
Contact for Review:	Head of Records Management
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	[redacted] **Adrian Harris**

CONTENTS

KEY POINTS OF THIS POLICY:

- This policy applies to the RD&E Health Record
- Adhering to the Data Protection Act 2018 and ensuring that personally identifiable information is kept secure at all times
- The policy applies to all staff who handle casenotes and/or deal with personally identifiable information and must be referred to to ensure correct process is followed

1. INTRODUCTION

1.1 Patient casenotes form part of the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) corporate memory, providing evidence of actions and decisions and representing a vital asset to support our daily functions and operations. They 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 us deliver our services in consistent and equitable ways.

1.2 The Trust is committed to improving the standards, quality and awareness of Health Records whilst ensuring that confidentiality is maintained at all times**.**

1.3 Sound records management ensures compliance with legislative requirements

1.4 Health Records serve many purposes the most important of which are:

- the contemporaneous recording of events and evaluations and;
- a communication medium between the people responsible for the care of a patient

1.5 They must contain sufficient information to identify the patient correctly, support the diagnosis and justify the treatment or interventions

1.6 Good record keeping is an integral part of professional practice and a mark of a skilled and safe practitioner. Healthcare team colleagues, temporary staff and all those sharing the care of a patient rely on accurate records

1.7 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE

2.1 The purpose of this document is to outline the Trust's Health Records Policy and establish how casenotes should be managed effectively and comprehensively

2.2 It is the policy of the Trust that:

- Information contained within the casenote (record) is kept confidential and restricted to those who need it;
- Information contained within the casenote (record) is accurate, up to date and in a structured format;
- Casenotes (records) are available when needed, held securely and tracked accurately; and
- Casenotes (records) are disposed of appropriately

2.3 This policy applies to all members of staff who handle and use patient casenotes

2.4 This policy has been produced to assist healthcare professionals to keep effective records

2.5 All healthcare practitioners must use their professional judgment to decide what is relevant and what should be recorded. All individual professions need to be aware of their professional responsibilities and accountability and must conform to individual codes of professional practice. This policy does not replace the standards, advice and guidance provided by respective professional organisations

3. DEFINITIONS

3.1 In the context of this policy, a **casenote** is anything which contains information in direct relation to the clinical history, diagnosis, treatment or review of a patient which has been created or gathered as a result of the work of NHS employees. The information can be paper based or electronic and include photographs, video tapes and CDs or any other record type related to the patient care pathway

3.2 **Health Records Management** is the process by which this Trust manages all aspects of clinical/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

3.3 **Contemporaneous record** is the term used for an accurate occurrence, so that information is documented continually

3.4 **Patient Administration System** (PAS) is the patient administration system used to track patients' casenotes, again whether paper or electronic. PAS is also referred to as the Tracer System, although the Tracer System is an integrated module of PAS

3.5 **eNotes** is the Electronic Document Management System that was used at the Trust to view scanned archive e-notes. These can now only be viewed from within the Health Records Department.

3.6 **Care Quality Assessment Tool** (CQAT) is a rolling audit programme of all inpatient wards, looking at essence of care nursing standards and clinical documentation

3.7 A **Multiple Registration** is where a patient is registered on PAS more than once

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **The Medical Director** is the Executive Trust Board officer with overall responsibility for Health Records within the Trust who provides assurance and advice to the Trust's Board of Directors of any risks associated with patient casenotes

4.2 The **Caldicott Guardian**, nominated as the Deputy Medical Director, has overall responsibility for the sharing and release of patient identifiable information

4.3 The **Associate Medical Directors** in each Division will ensure all healthcare professionals that use or come into contact with casenotes or electronic patient records will adhere to the Health Records Policy and procedures at all times. This will be done through CQAT

4.4 The **Head of Records Management** is responsible for the management and co-ordination of patient casenotes, ensuring a responsive and customer focused Health Records service. This post reports directly to the Head of IM&T Systems, who in turn reports to the Chief Information Officer.

4.5 The **Information Governance Manager** is responsible for promoting Information Governance throughout the Trust and for ensuring that staff awareness is maintained and legislation complied with

4.6 The **Administrative Services Manager** for Health Records assists the Head of Records Management and deputises for them during periods of absence

4.7 All **Admin and Clerical Staff** are responsible for ensuring documentation generated regarding the clinical care of the patient is filed timely within the patient's casenotes, as well as the accurate recording of casenote movement on PAS

4.8 **Ward Clerks** during daytime hours are responsible for all filing within the patient casenotes for inpatient and day case admissions. Out of hours, it is the responsibility of the **Matron** of the Ward to ensure that any documentation produced whilst the patient is an inpatient on their ward, or daycase within daycase facilities, is filed timely within the patient's casenotes

4.9 **The Core Support Team** is responsible for the merging of multiple casenotes and allocating hospital numbers both on the PAS master patient index, which is applied then to all electronic systems interfaced with PAS, and the physical casenotes

4.10 **Missing Casenote Co-ordinator** is responsible for locating any missing casenotes

4.11 **All staff** who have access to Health Records must maintain patient confidentiality at all times and adhere to the Trust's Data Protection Policy; a breach of this Policy may lead to disciplinary action, which could lead to dismissal

4.12 The **Information Governance Steering Group**, through the Records Management Group, is responsible for endorsing the Health Records Policy and procedures, reviewing duties and responsibilities and resolving any issues in relation to the non-compliance of this policy. The Health Records Document Approval Group is responsible for ratifying all documentation to be filed within the casenotes

5. STANDARDS FOR RECORD KEEPING

5.1 A record is a structured document which contains information (in any form of media), which has been created or gathered as a result of any aspect of the work of the NHS employees. These records must be continually updated to ensure their validity and use, unless the information contained in the record becomes obsolete. They must be structured in a consistent way so that information can be retrieved quickly and easily

5.2 All healthcare professionals have a legal duty of care; record keeping should be able to demonstrate

- A full account of all assessments and the care planned and provided;
- Relevant information about the condition of the patient at any given time and the measures taken to respond to their needs; and
- Evidence that the duty of care has been understood and honoured and that all reasonable steps to care for the patient have been taken

5.3 Records may be required as evidence:

- Before a court of law;
- In order to investigate a complaint at a local level; and
- By Professional Conduct Committees eg NMC and GMC, which considers complaints about professional misconduct

5.4 The following guidance is a statement of good practice that has been taken from the professional standards for record keeping, and the Trust advocates that all healthcare professionals should consider these when documenting patient care

All records should:

- Be patient identifiable by NHS and Hospital Number;
- Be clear and unambiguous;
- Be factual, consistent and accurate;
- Be written as soon after the event as possible;
- Be clearly attributable to the person recording the information;
- Contain minimum abbreviations;
- Include details of all information that has been discussed/given to the patient/relatives/carers regarding the patient's care and treatment; and
- SHOULD NOT contain irrelevant phrases or opinions, needless speculation, or any offensive comments about the patient

5.5 The core standards which must be adhered to by all professional groups when information is recorded in the patient's casenotes can be found in Appendix 1. These standards will be audited by the Care Quality Assessment Tool (CQAT) which is a rolling audit programme targeting all inpatient wards. The results of the CQAT audit and action plans will be reported by the Records Management Group to the Information Governance Steering Group and through to the Safety and Risk Committee

6. SAFEGUARDING

6.1 Where a patient attends the hospital and there is a safeguarding concern sheet at the front of the casenotes, practitioners are reminded of the need to check for a safeguarding divider and to read all information relevant to the care and safeguarding of that patient. See Appendix 2

7. TRAINING

7.1 Any clinical staff writing in the patient's casenotes must undertake the Importance of Good Clinical Record Keeping training on the Connecting for Health website. https://www.igtt.hscic.gov.uk/igte/index.cfm. It is the responsibility of the member of staff to ensure they can provide evidence of their successful completion of this training to their respective manager in order for ESR to be updated

7.2 All administrative and clerical staff and any other staff group who are required to file information in the casenotes must attend Casenote Training which is delivered by the Health Records Department before they undertake such duties. It is the responsibility of their line manager to ensure they arrange Casenote Training within two weeks of their start date, as part of their induction

7.3 All staff who are responsible for recording the movement of casenotes must attend PAS IT Training before they undertake these duties and it is the responsibility of their line manager to ensure they arrange appropriate training. PAS access is not given until training has taken place

8. CASENOTE CREATION/MANAGEMENT

8.1 New casenotes are created for a patient when they attend the Trust for the first time as either an outpatient or as an inpatient. They are registered on PAS and a unique number is allocated that relates to the complete record of care. The unique number is arranged in a record keeping system known as terminal digit that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information and ensure patient safety

8.2 Where patients have a "**NO NOTES", "OLD CASENOTES DESTROYED**" or "**SCANNED RECORD**" flag on PAS casenotes will be created when the patient attends the hospital or there is documentation that needs to be filed within the record

8.3 New patient registrations on PAS and casenote creation must only be carried out when the appropriate PAS and Casenote Training has been undertaken. Once the casenote folder has been created it must be tracered immediately on PAS

8.4 A system has been put in place in relation to Records Management that supports safe patient care in the event of a **major incident**. A process has been developed which should be followed to share patient identifiable information of specified patient groups during a major incident on request of a Multi-Agency Strategic or Tactical Co-ordinating Group, or a Vulnerable People Co-ordination Group set up by one of the afore mentioned groups. See Appendix 8

8.5 If a patient is a **transgender** patient their records may need updating and the Core Support Team on ext [redacted] should be contacted. It is important that this is done in a timely manner to avoid any undue stress to the patient. The Trust and its staff are governed by a duty of confidentiality with regard to information concerning patients and must not voluntarily disclose it without the express and informed consent of the patient

8.6 If a child is **adopted** the Core Support Team should be alerted who will obtain the casenote. When the details and new NHS number have been confirmed the old NHS number will be deleted from PAS and replaced with the new NHS number. The notes will be placed in a new casenote folder using the existing hospital number and the new name of the child. The child's former name is not recorded on PAS

8.7 When a **patient dies**, PAS should be notified immediately to ensure all future appointments and planned treatment are cancelled. If a patient dies within the Trust, it is the responsibility of the ward staff to immediately notify Core Support (Data Quality) on Ext [redacted] or Ward Support (Bleep [redacted]) if it is outside normal working hours. A `DIED ON` sticker, if available, should be attached to the bottom right hand corner of the front cover with the date of death recorded. If a sticker isn't available then just write the date of death in bottom right hand corner.

8.8 If the patient dies outside the Trust, Core Support (Data Quality) on Ext [redacted] or Ward Support (Bleep [redacted]) should be contacted and casenotes returned to the Health Records Department. Deceased patients' casenotes are not stored on site

8.9 **HEALTH RECORDS PROCEDURES**

Appendix 1: Record Keeping Standards
Appendix 2: Filing Documentation in the Casenotes
Appendix 3: Process for Creating Casenotes (New, Temporary, Non-current, major incident)
Appendix 4: Requesting and Provision of Casenotes
Appendix 5:Clinic Prep Standard
Appendix 6:Securing Handling, Tracking and Transportation of Casenotes
Appendix 7:Requests for Access to Personal Data
Appendix 8:Sharing Personal Information in a Major incident
Appendix 9:Destruction and Retention of Casenotes
Appendix 10:Disclosure of Information to the Police Procedure

9. REQUESTING AND PROVISION OF CASENOTES

9.1 If casenotes are needed for an Emergency Admission, Health Records have an emergency telephone line (ext [redacted]). Notes requested through this route as an Emergency Admission will be delivered within 1 hour as long as the notes are on the Trust site. See Appendix 4

9.2 Should notes be needed urgently but not for an Emergency Admission, the emergency telephone line (Ext [redacted]) can be used to request up to 3 sets of notes where the PAS tracer location is within a Health Records Storage area. The records will be available for collection from the Health Records Department the same working day. Any notes not collected from Health Records on the day will be returned to `Prefile`. If the notes required are tracered to a nonHealth Records location the requester must contact the location and arrange to collect the notes

9.3 If more than 3 sets of notes are required, then either an Urgent Pulling List can be created on PAS, which will be delivered by Health Records the next working day, or a Routine Pulling list created which will delivered within 1-4 working days

9.4 Where Health Records prepare and provide casenotes for a patient's outpatient appointment, the notes will prepped to include the referral letter (where the patient is a new patient) two clear sides of a Continuation Sheet and 2 sets of patient ID labels. The notes for clinics will be delivered in the morning for an afternoon clinic and in the afternoon for the following morning's clinic. See Appendix 5

9.5 Where clinics are prepped in an area outside of Health Records the same processes must be followed to ensure standards and consistency are maintained

10. FILING DOCUMENTATION WITHIN THE CASENOTE

10.1 A consistent approach to the filing of documents, reflecting the continuum of patient care, ensures clinical information is held securely and can be quickly and easily located

10.2 All documents must be filed securely in the body of the casenotes behind the appropriate divider and in the agreed order, checking patient details first to avoid mis-filing in the wrong patients casenotes. Where forms in current usage are not listed the Head of Records Management should be contacted for guidance

10.3 All clinical documentation must be approved for filing in the casenote by the Health Records Document Approval Group, it will be allocated a Unique Identifier (UKD) number. Where it is a Trust document it will have a box on the bottom indicating where within the notes the document should be filed. Please see Appendix 2 for details on the structure of the casenote and where and how information is filed

10.4 Casenote Training is provided by the Health Records Department and is mandatory to all staff filing within the casenotes; this includes Admin and Clerical staff and nursing staff if filing within the casenotes forms part of their role. This training can be booked through the line manager using the Trust Intranet. Filing in casenotes must only be carried out after the appropriate training has been completed

11. MOVING, HANDLING AND TRANSPORTING NOTES

11.1 All casenotes must be handled safely and securely to ensure that confidentiality is maintained at all times. All movement must be accurately recorded on PAS to ensure casenotes can be located when they are needed. Casenotes must be tracered when leaving a location to the location to where they are being sent/delivered and must be tracered to the receiving location upon receipt. If a patient has more than one volume, each volume must be tracered using the multi-volume tracering functionality on PAS

11.2 Any member of staff responsible for moving casenotes must attend PAS training to ensure they are able to record their movement on PAS. If notes need to be tracered in an emergency and there is no-one who can tracer them, Health Records should be contacted on ext [redacted] with details of the location they are going to, including the extension number and who will then tracer them

11.3 The last location tracered on PAS is responsible for locating the casenotes when they are requested. After thorough searches are made in the area, if still not found, the Missing Casenote Co-ordinator should be informed who will make further searches and record on Datix as an incident.

11.4 All casenotes being transported around the Trust should be in sealed envelopes, secure bags or in notes trolleys, face down. Confidentiality must be maintained at all times and personal information kept secure.

The Trust has a service for the delivery of urgent casenotes across sites which should only be used in the event of the patient becoming an inpatient on a ward, waiting to be seen by a team, or in an outpatient setting, and the healthcare professionals require the health record to enable delivery of care

11.5 On no account should patients be asked to transport their own notes within or across Trust sites. Only appropriate staff should transport casenotes, e.g. Porters, ward or ambulance staff. Only in exceptional circumstances, and as agreed by the clinician, where there is an absence of appropriate staff, and only if a lockable bag is available, may patients be given their own notes to transport within the Trust site

11.6 In the case of patients being transferred from a Trust ward to a community hospital within Exeter, East and Mid Devon, the patient's casenotes must accompany the patient and be handed to the Ambulance service taking the patient for safe transportation.
If the patient is being transferred to a location outside of these then photocopies and not the original casenotes will be sent. The relevant information should be photocopied by the area transferring the patient and put in a sealed envelope to be transported with the patient

11.7 Where patients are seen at external locations the casenotes must only be transported by either the Trust Transport department or by an approved courier service. Should external mail be used then casenotes should be sent by Recorded or Special Delivery only

11.8 In exceptional circumstances where there is no Trust Transport or courier service available and the casenotes need to be transported, the clinician may transport them. In circumstances where the clinician is not returning to the Trust at the end of the working day, the casenotes should remain in a secure/lockable case in the safest location available, e.g. the clinician's home. Casenotes must not be left in the car boot overnight

11.9 Care must be taken to ensure that family members or visitors to the clinician's house do not gain access to the casenotes and that confidentiality is upheld. The admin staff must tracer the casenotes on PAS to record their location in case they are needed in an emergency (e.g. `Cons Home` in the Comment Section) , in which case it will be the responsibility of the clinician to return them to the Trust. The casenotes must be returned to the Trust by the clinician the next day. They should be returned to the relevant area where they should be checked to ensure that all casenotes are accounted for and the tracer must be updated to accurately record the location of the casenotes

11.10 If a clinician is visiting an individual patient in a residential setting, only the casenote for that patient should be taken into the building. Any remaining records should be in a bag or box and locked in the boot of the car out of sight. If it is considered that it would be safer from a theft and/or risk management point of view to take all records into the residence, then these should be taken in and kept in a secure/lockable case

11.11 Casenotes or any other papers containing personal identifiable data must not be left on car seats visible to passers-by

12. STORAGE OF CASENOTES

12.1 Casenotes should be stored by the Health Records Department in their closed secure storage areas when they are not in use. The Health Records Department is a closed area and access is restricted

12.2 Any area that store casenotes in bulk for short periods, such as Maternity Records and the Renal Filing Room, must ensure that the area is secure and access is restricted. Casenotes must be managed in accordance with Health Records processes for secure and efficient storage and follow professional advice on records management from the Head of Records Management

12.3 Where casenotes are in use and temporarily stored in offices, the offices should be locked overnight and during periods of absence. Casenotes should be kept away from windows and areas where they can be viewed by those not needing to see them e.g. visitors or the general public

12.4 Where casenotes are in use in Reception, Outpatient Areas and Wards they must be kept secure, not left unattended and patient confidentiality must be protected at all times. The patient name on the front of the casenote should not be visible to patients, visitors or the general public

12.5 At all times casenotes must be stored in secured NHS sites and tracered accordingly. Casenotes must not be stored in private dwellings or vehicles. (Except in exceptional circumstances, please see 11.7 – 11.11 above)

12.6 In order to maintain efficient storage areas, the Health Records live storage areas will be checked on a monthly basis for casenotes of patients who have not been seen for two years. These notes will be moved to a non-live storage area and only retrieved during normal working hours if requested. Out of hours, including over the weekend and bank holidays, they will not be retrieved and a temporary folder will be raised. Where the patient record is on eNotes, these can only be viewed in the Health Records Department by prior arrangement preferrably.

13. DESTRUCTION AND RETENTION OF CASENOTES

13.1 Retention guidance from the NHS Digital Records Management Code of Practice for Health and Social Care 2016 detailing minimum retention periods is followed by the Trust. Location exceptions to the destruction criteria and minimum retention periods are detailed further in Appendix I

13.2 The aim is to minimise storage and retrieval, improve the standard of casenotes and ensure clinical requirements for clinical information is maintained. This policy applies to the main Trust record used Trust-wide and not any other personal health records held elsewhere. Other departments which keep their own records should ensure that they refer to the NHS Digital Records Management Code of Practice for Health and Social Care 2016

14. DATA PROTECTION ACT 2018 AND DUTY OF CONFIDENTIALITY

14.1 All NHS bodies and those carrying out functions on behalf of the NHS have a common law duty of confidentiality. Everyone working for or with the NHS who records, handles, stores or otherwise accesses patient information has a personal common law duty of confidentiality to patients and to their employer. This duty of confidentiality continues after the death of the patient or after an employee or contractor has left the NHS

14.2 The Data Protection Act 2018 establishes a set of principles (7) which users of personal information must comply with. Personal information must be:

- Lawfulness, fairness and transparency
- Purpose limitation
- Data minimisation
- Accuracy
- Storage limitation
- Integrity and confidentiality (security)
- Accountability

The Act also imposes statutory restrictions on the use of personal information, which must not be used for purposes other than those declared in the Trust's Data Protection Act registration. The guidelines contained within this policy underpin the principles of the Data Protection Act 2018 and ensures that personal information is accurate, up to date and retrievable in a timely manner

14.3 Day-to-day management responsibility for the Trust's compliance with the Data Protection Act 2018 including the security of person identifiable health data is managed

by the Information Governance Manager as Data Protection Officer, in conjunction with the Caldicott Guardian

14.4 All requests for copies of health records from patients, solicitors, police and the courts must be made to the Information Governance Office. All requests by patients for copies of their health records is dealt with as a Subject Access Request Appendix 7. Where the Police request information this is dealt with under Schedule 2 Part 1 Para 2 Data Protection Act 2018 (previously Section 29 of the Data Protection Act) see Appendix 8

14.5 Where staff are handling casenotes of other staff, friends or relatives they must report this immediately to their line manager who will consider if it is appropriate for them to handle them

15. FREEDOM OF INFORMATION ACT 2000

15.1 The Freedom of Information Act 2000 (FOIA) gives a general right of access to all types of recorded information held by public authorities, subject to certain conditions and exemptions contained in the Act. However, it does not include access to person identifiable data which is covered by the Data Protection Act 2018

16. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

17. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

17.1 To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Standard of Record Keeping – Inpatient wards	CQAT Audit Reports Action Plans Results fed back to the Clinical Directorate to be discussed at Directorate Governance Meetings and quarterly review and Clinical Audit. Clinical Audit submits to the Records Management Group	Divisions Records Management Group
Standard of filing within casenotes	Audit a selection of recent inpatients twice a year (10 sets of casenotes per speciality) and feedback results to Directorate	Admin Services Manager Head of Records Management
Contemporaneous	CQAT Audit Reports Action Plans	Divisions

entries	Results fed back to the Clinical Directorate to be discussed at Directorate Governance Meetings and quarterly review and Clinical Audit. Clinical Audit submits to the Records Management Group	Records Management Group
Casenote Training	Liaise with IT Training to obtain a list of staff that have attended PAS Level 1 and 2 to ensure attended casenote Training. Bi-monthly	Health Records Core Support Admin Services Manager
Review of Health Records Procedure Appendices	Conducted as service needs change by the Head of Records Management	Head of Records Management

REFERENCES

NHS Digital Records Management Code of Practice for Health and Social Care 2016
Data Protection Policy
Data QualityPolicy
Records Management Policy
Records Management Strategy
Information Security Policy
Freedom of Information Act 2000
Data Protection Act 2018
Access Policy
Department of Health Code of Practice Care Quality Assessment Tool
http://www.connectingforhealth.nhs.uk/igtrainingtool
Health Records Document Approval Group
European Economic Area
Freedom of Information Act 2000

APPENDIX 1: RECORD KEEPING STANDARDS

1. RECORD KEEPING STANDARDS

The following core standards must be adhered to by all professional groups when information is recorded in the patient's casenotes. These standards will be audited by the Care Quality Assessment Tool (CQAT).

Entries to casenotes should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round or investigation) and before the relevant staff member goes off duty. In cases where the latter is not possible, the time of the event and the reason for the delay should be recorded. Entries made in retrospect should ideally be identified as such when they are written, and both the time of the entry and the time of the event recorded

1.1 **All entries must:**

- Be written on a page with the patient's name, date of birth (D.O.B) and hospital/NHS number
- Be written in black ink (with an exception of red for operation notes and green for Pharmacists)
- Be in chronological order within each speciality to reflect the continuum of patient care
- Be accurately dated (using DD/MM/YYYY) and timed (using the 24 hour clock HH:MM)
- Identify the most senior clinician present – specifically on ward rounds
- Be legible so that others can read the text
- Be signed by the clinician making the entry, together with their name in BLOCK CAPITALS, designation and bleep number (if held). If an Integrated Care Pathway (ICP) is in use and initials only are used, there must be corresponding full, clear identification, as above, of all clinicians who document care within the ICP documentation; all healthcare professionals providing care must complete this legend before documenting in the ICP
- Be dated, timed and signed if there are amendments or additions
- Be deleted, in the event of an error by ~~**striking through the entry with a single line**~~**,** so that the original entry is still legible. The correct entry is then made. Never erase or use correcting fluid
- Be written without leaving spaces between entries, if gaps found, strike through the page(s)
- Be written in full the first time an abbreviation is used, followed by the abbreviation in brackets (although abbreviations should be kept to a
- minimum)

1.2 **Clinical Alert**

If the patient has an allergy or any other alert, this should be recorded, by the clinician responsible for the care of the patient, in the Clinical Alert Box inside the front cover of the casenote. This entry must be dated and signed.

1.3 **Incident Reporting**

If staff find a patient's casenotes are incomplete or contain misfiled documentation then a Datix Report must be completed (Incident Reporting)

1.4 **Audit**

Six sets of casenotes per ward will be audited as part of CQAT. An audit report will be produced and should include the following:

- Areas of good practice
- Areas requiring improvement
- Conclusion
- Recommendations
- Action plan and review date

Results and a copy of the action plan must be fed back to the Associate Medical Directors for discussion at Divisional Governance Group meetings and Quarterly Review and to Clinical Audit for submission to the Records Management Group, as part of the Information Governance Steering Group.

The Information Governance Steering Group is chaired by the Medical Director, or Deputy, who is a member of the Trust Board of Directors. The Steering Group also provides regular reports to the Safety and Risk Committee, with results of CQAT being part of this report

APPENDIX 2: FILING DOCUMENTATION IN THE CASENOTES

2.1 Filing in casenotes must only be carried out after the appropriate casenote training has been undertaken, which is delivered by the Health Records Department Care must be taken to ensure the document is filed into the correct set of casenotes.

All documents must be filed securely within the casenotes in the Trust agreed order. The ward/department producing the documentation is responsible for its correct and secure filing. Every member of staff handling casenotes has a duty of care to ensure that they are kept in good condition and maintained in line with Trust standards

Guidance of filing order can be found on the inside cover of casenotes and on the front of each divider

2.2 PLASTIC WALLET/FRONT POCKET

Patient ID Labels - To be filed in the A4 plastic wallet or front inside pocket

Outcome Slips and Referral Letters - The only documents to be 'temporarily filed' in these pockets, pending outpatient appointment

2.3 IN FRONT OF DIVIDERS

Patient Identification Sheet - (code no.WKG650C) must be filed in front of all documentation and dividers.

Record of all Paediatric Clinic Information held by RD&E **(yellow A5 sheet)** This sheet must be present in all paediatric casenotes. To be filed directly in front of the Patient Identification Sheet.

Safeguarding Concerns sheet (yellow sheet) – To be filed immediately behind the Patient Identification Sheet. It is created and stored on CDM which is updated every time there is relevant formal safeguarding meetings and the previous copy removed.

Advance Directive/Living Wills - To be filed immediately behind the Patient Identification Sheet.

Treatment Escalation Plan (TEP) – To be filed immediately behind the Patient Identification Sheet

Photocopying of Casenotes Form - To be filed behind the Patient Identification Sheet, and before the Clinical Notes divider.

Contents of Volume Form - To be completed and filed in each volume in front of the Patient Identification Sheet when large volumes are split into current and non- current volumes.

Risk and Monitoring Proforma –To be filed behind the Patient Identification Sheet and before the Clinical Notes divider. This proforma is completed as part of the Challenging behaviour and management plan.

High risk/High Profile (VIP) Patient – Patient Name Change Form – To be filed behind the Patient Identification Sheet and before the Clinical Notes divider

2.4 CLINICAL NOTES DIVIDER

Discharge Summaries - Must be filed immediately behind the divider, before the clinical history sheets and in reverse chronological order, i.e. most recent on the top.

Clinical History Sheets - Must be filed behind discharge summaries, in chronological order by specialty.

Obstetric Records - Complete obstetric records for each pregnancy will be filed in the Clinical Notes section. See 2.11 for obstetric filing order.

Foetal Heart Traces and CTG Results - To be placed in an envelope, sealed and marked with a patient ID label. The envelope should be hole punched and filed within the obstetric record.

ED Record: Adults - If a patient is admitted from ED, a copy of the ED record should be made and filed at the beginning of the clinical history sheets for that episode. The Ambulance Communication form should also be copied and filed at the beginning of the clinical history sheets for that episode, if applicable.

ED Record: Paediatrics - All children who attend ED (whether subsequently admitted or not) must have a copy of the ED record filed in their casenotes.

Operation Notes – filed after relevant clinical entry

Correspondence 'Stickies' - File in chronological order immediately after relevant clinical entry.

Multidisciplinary Management Care Plans - When in booklet format, to be filed in place of standard clinical history sheets

2.5 CORRESPONDENCE DIVIDER

Correspondence - All correspondence including the casenote (green) copy of the TTO form, must be filed in reverse chronological order. Original correspondence must be filed, but copies to be disposed of in confidential waste once seen by the recipient.

Safeguarding Folder (yellow) - To be filed at the very back of the Correspondence section. This folder should be used to store any minutes relating to safeguarding meetings. Documentation contained within this folder should be filed in reverse chronological order.

Photocopied Records from Other Hospitals - To be filed within the Correspondence section

2.6 INVESTIGATION RESULTS DIVIDER

Mount Sheets are filed as follows:

- Haematology/Blood Transfusion
- Biochemistry
- Other pathology

Small Investigation Results - **Must be attached to the appropriate mount sheet or hole punched and be signed by a Clinician. Mount sheets filed in reverse chronological order if multiple sheets of same type**

Oversized Results - Investigation results that do not fit on a mount sheet, e.g. photograph, should be hole punched and filed in reverse chronological order behind the 'Other Pathology' mount sheet. The investigation results should be filed in the following order

- A4 history reports
- Radiology
- ECG's
- Cardiac – catheter reports, echocardiograms etc
- Other reports

Any reports not suitable for hole punching or mounting e.g. scans, must be placed in an envelope, sealed and marked with a patient ID label

2.7 CHARTS AND SPECIAL SHEETS DIVIDER

Consent Forms, Anaesthetic Records and Growth/Weight Charts - Must be filed immediately behind the divider, before the nursing documentation, and in reverse chronological order. To be filed as follows

- Consent forms
- Anaesthetic records
- Growth /weight charts

Nursing Documentation - Nursing documentation to be filed by episode. Complete episodes to be filed in chronological order

Nursing Documentation to be filed as follows

- Admission form
- Patient assessment form
- Care plans
- Discharge outcomes
- Pre op nurse check list
- Temperature charts
- Fluid balance charts
- Other
- Drug prescription chart

Physiotherapy and OT notes - To be filed in the relevant episode of care

Renal Nursing Notes - The last episode only is to be filed within the casenotes. This should be removed when filing the next episode, and stored within the Renal Unit

2.8 CASENOTES FOR CHILDREN

A yellow A5 sheet, 'Record of all Paediatric Clinic Information held by RD&E' should be undertaken by anyone creating a set of notes or using a set of notes, where this is not already in place

2.9 FRONT/BACK POCKETS

Where older style casenotes have a pocket on the inside front and/or back cover, under no circumstance should this be used to store any document

2.10 MISCELLANEOUS

Ophthalmology Records - All ophthalmology records, i.e. clinical notes, correspondence, investigation results and nursing notes to be filed behind a blue ophthalmology specialty divider, for new patients this goes at the back of the Clinical Notes section, historically this can also be found at the very back of the casenotes. The same rules apply within this section for the order of filing

Legal Correspondence and Complaints - Must NOT be filed in the patient's casenotes. File in an administration file, which should be held in the relevant consultant's secretary's office

No dividers in Casenotes - In the event of casenotes with no dividers (pre 1984), dividers should be added and the current Order of Filing Procedure followed

Not all forms and documents in current usage are identified in the above procedure. Contact the Head of Records Management for guidance

2.11 COMPLETE OBSTETRIC RECORDS FOR EACH PREGNANCY ARE FILED IN THE CLINICAL NOTES SECTION OF THE HEALTH RECORD

- **Yellow safeguarding children folder (if needed)** – the folder is removed when the baby is born and the information contained within the folder is filed within the baby's notes

Domestic abuse screening form **Prediction and detection of mental health illness** (if appropriate) **FTSC booking form**
Consultant care or opinion referral letter **Correspondence**
Hand held green pregnancy booklet **Diabetic notes – if required**
Antenatal admission sheet **STORK antenatal discharge letters** (in chronological order)

Results mount sheet and ECGs *(only paper copies of results will be filed if they indicate a result that is not normal. Normal results will be shredded*

Induction proforma if appropriate **Yellow birth notes**

- **CTG's in brown envelope** (*affix label, write on year and close, secure with treasury tag)*
- **Epidural charts/anaesthetic chart/consent form/fluid chart/early warning scores etc** **Shoulder dystocia proforma** (if used)
- **Pink PLATO form** *(if caesarean section or instrumental procedure)*
- **Suturing proforma** **Purple postnatal notes (care plans) – when returned from community midwife** **Postnatal appointment sheet**

PLEASE NOTE: STORK Discharge Summary to be filed with all other
Discharge Summaries – Discharge summaries are filed immediately behind the Clinical Notes Divider, before the clinical history sheets and in reverse chronological order, ie most recent Discharge Summary on top

2.12 CASENOTES OF CHILDREN AND ADULTS WHO ARE SUBJECT TO SAFEGUARDING PROCEDURES

When the decision is made that a child or adult is to be subject to formal safeguarding procedures i.e. strategy meetings, case conference, MARAC, the Safeguarding Team Secretary will insert a Safeguarding Concerns sheet (yellow paper) in the front of the casenotes immediately behind the Patient Identification Sheet. This sheet will be created and stored on CDM. A yellow safeguarding folder will be placed in the casenotes at the back of the correspondence chapter and will contain any minutes of safeguarding meetings

The Safeguarding Concern sheet will be updated every time there is relevant formal safeguarding meetings and will be replaced in the casenotes and updated on CDM (responsibility of Safeguarding Team secretary). The previous Safeguarding Concern sheet will be removed

2.12.1 **Documentation stored within the Safeguarding Divider**

The safeguarding divider should be used to store any minutes relating to safeguarding meetings. Documentation contained within this section should be filed in reverse chronological order

Where child protection strategy or case conference minutes relate to an unborn child, the minutes should be filed in the mother's casenotes within a safeguarding divider within the Correspondence chapter of the casenotes. These should be photocopied and then transferred to the child's casenotes once the child is born and filed in Safeguarding Divider in the Correspondence chapter. The original should remain in the mother's records. The yellow safeguarding concern sheet should be retained within the mother's casenotes

2.12.2 **Patient with a Safeguarding Divider who attend the Hospital**

Where a patient attends the hospital and there is a safeguarding concern sheet at the front of the casenotes, practitioners are reminded of the need to check for a safeguarding divider and to read any relevant information essential to the care and safeguarding of that patient

2.12.3 **Access to the contents of the Safeguarding Divider**

Access to information contained within this section is covered under the Data Protection Act 2018.

Subject Access requests or requests made by parents/guardians will be processed in line with the Data Protection Act 2018 and Trust's Subject Access Request (SAR) Policy Requests for Access to Personal Data Procedure

2.13 NEW DOCUMENTATION

All new documentation for inclusion within the health record must be approved by the Health Records Document Approval Group. Guidance on the process along with sample templates are available on the intranet: Health Record Document Approval Group Home Page. Any document that is to be piloted must go through the same process

APPENDIX 3: PROCESS FOR CREATING CASENOTES (NEW, TEMPORARY, NON-CURRENT AND MAJOR INCIDENT)

3.1 **NEW CASENOTES FOLDER**

Casenotes must only be created after the appropriate Casenote training has been undertaken, which is delivered by the Health Records Department. Casenotes must only be created if no RD&E casenote folder already exists. When creating a new casenote it is important to ensure the required checks are made to verify that the patient does not already have an existing record. The procedure set out in the PAS training manual for the registering of patients must be followed

3.1.2 For **new patients** where a hospital number is not immediately allocated a numbered casenote folder must be used. For patients who are **No Notes, Scanned or**

Casenotes Destroyed, an un-numbered casenote folder must be used. They must be created as follows

- The patient's name must be written clearly in black ink that cannot be erased. The surname is to be written in capital letters, followed by the forename(s) in lower case
- The patient's NHS Number must be written clearly in black ink in the box provided on the front cover
- Where un-numbered casenote folders are used the RD&E hospital number on PAS should be recorded on the new casenote folder. The digits must be written in 3 pairs followed by the check digit, e.g. 12 34 56 7
- When resurrecting a casenote folder following destruction of the original, an 'OLD CASENOTES DESTROYED' sticker should be affixed inside the front cover, in the top left hand corner. A supply of stickers is available from Health Records
- The Health Records Department will create a casenote folder for patients who only have a record on eNotes an 'e' sticker will be placed on the front cover on the right hand side and a sticker will be placed in the Clinical Alert Box on the inside front cover stating that the patient also has a scanned record which could be viewed
- 1 sheet of patient ID labels should be printed. One label should be affixed to the Patient Identification Sheet, and the remaining labels filed in the plastic wallet

Once a set of casenotes has been created they must be tracered immediately to the person and location creating the casenotes (failure to do so could result in a duplicate folder being created).

3.2 TEMPORARY FOLDERS

A red temporary folder will only be created when:

- An extensive and thorough search has been undertaken and the original casenotes cannot be found
- The original casenotes cannot be retrieved from current location prior to patient activity taking place, e.g. they are located off site. The original casenotes should still be requested and retrieved at the earliest opportunity

In the event that a set of casenotes cannot be located and an extensive search has been undertaken, the Missing Casenotes Coordinator should be contacted on ext [redacted], for further advice. The Missing Notes Coordinator will liaise with the requester to ensure a thorough search is undertaken. If casenotes cannot be located, a temporary folder is created, if required by requester.

Temporary folders are created primarily by Health Records staff, but can also be created by other Trust staff, who have completed the appropriate training and only after discussing with the Head of Records Management

Temporary folders will contain a clinical history sheet, one sheet of ID labels and relevant documentation from CDM.

All temporary folders are recorded on the Temporary Folder database by the Missing Notes Coordinator. The database enables monitoring and audit of the temporary folders

3.2.1 **Tracering of Temporary Folders**

They will be set up as a multi-volume and tracered. The multi-volume tracer must be used to record any further movement of the temporary folder until the originals are found.

3.2.2 **Large Temporary Folders**

In the event that the temporary folder becomes too bulky and difficult to use, the Missing Notes Coordinator based in Health Records will transfer the contents to a medi-clip style folder

3.2.3 **Locating Original Casenotes**

Original casenotes are searched for on a regular basis by the Missing Notes and are recorded on the 'Temporary Folder Form'

Locating original casenotes for inpatients or outpatient attendances is a priority

3.2.4 **Amalgamating a Temporary Folder with the Original Casenotes**

As soon as an original set of casenotes is located, the Missing Notes Coordinator must be contacted on ext [redacted], so that the original casenotes and temporary folder can be amalgamated and PAS updated. Out of hours Ward Support can be contacted on bleep [redacted]. Upon location, the original casenotes must be tracered immediately.

Either the person holding both sets or the Missing Casenote Co-ordinator will amalgamate the temporary folder with the original casenote and will tracer on PAS to indicate that the originals and temporary casenotes have been amalgamated.

3.2.5 **Monitoring and Audits of Temporary Folders**

The Missing Notes Coordinator maintains a record of all temporary folders. This information is used to highlight issues and areas for improvement, such as identifying training needs. The following audits are circulated

- Head of Records Management and ASM for Health Records – the number and details of temporary folders created, provided on a monthly basis.
- ASMs – the number and details of casenotes found to be missing within their directorate, provided on a monthly basis.
- ASMs – the number and details of ALL outstanding casenotes missing within their directorate, provided on a quarterly basis

3.3 CREATING NON CURRENT VOLUMES

3.3.1 Bulky casenotes must only be divided into current and non-current volumes by staff who have undertaken the appropriate training, organised by the Health Records Department.

3.3.2 If a casenote folder becomes overloaded and bulky, the folder should be secured with an elastic band and given to the designated member of staff in the Division to split. If unknown, the appropriate ASM should be contacted for further advice

3.3.3 Casenotes that require splitting will be divided into the 3 volumes as follows

- Volume I (current)
- Volume II (non-current) - to include non-current Clinical Notes and correspondence

- Volume III (non-current) - to include non-current Investigations and Charts & Special Sheets

The current volume will be marked 'current' and the non-current volumes marked 'non-current'. All volumes will be numbered using roman numerals, indicating the volume number and how many volumes exist, e.g. 'Volume I of III'. Non-current volumes must always be the final volumes, with the most recent non-current volumes at the end

3.3.4 Should more non-current volumes be required, these will be split as 4.3, and then divided by date.

3.3.5 In some circumstances it may be necessary to create more than one current volume. One volume should contain clinical notes and correspondence, the other volume investigation results and charts & special sheets. The casenotes should be labelled accordingly, e.g. 'Volume I of IV Current' and 'Volume II of IV Current'

When creating additional volumes, any existing volumes should be retrieved and re-labelled as appropriate

A Contents of Volumes form will be placed in each volume, filed in front of the Patient Identification Sheet

All alerts will be replicated on all newly created volumes on inside front cover of new volume, in the 'Clinical Alert' section

3.4 CONTENTS OF MULTI VOLUME CASENOTES

3.4.1

	Volume 1 Current	**Patients under 18 years of age Volume 1 (current)**
Clinical Notes:	1 year All Discharge Summaries All Operation Notes	2 years All Discharge Summaries All Operation Notes Obstetric notes 3 years
Correspondence:	3 years All Safeguarding Children	2 years correspondence from RDE All correspondence from outside RDE All Safeguarding Children information
Investigations:	1 year	1 year
	All Echocardiograms ECGs - 1 year	All Echocardiograms ECGs - 1 year
	Pulmonary Function tests - 1 year	Pulmonary Function tests - 1 year
		Obstetrics notes over 3

Correspondence	Over 3 years	Charts and special sheets Previous episodes of nursing care. Other consent forms

Or

Charts & Special Sheets:	Last admission form Last relevant consent forms All Anaesthetic Records	Last admission form Last relevant consent forms All Anaesthetic Records All Transfusion Records All Growth Charts
Ophthalmology:	All notes	All notes

3.4.2 Volume II (non – current)

		Patients under 18 years **Of Age Volume II (non – current)**
Clinical Notes	Over 1 year	**Investigations**

Nursing charts only

3.4.3 **Volume III (non Current)**

Investigations	Over 1 year
Charts and sheets	Previous episodes of nursing care special Other consent forms

3.5 STORAGE AND RETRIEVAL OF NON-CURRENT VOLUMES

3.5.1 Current and non-current volumes will be stored separately. Current volumes will be filed in Store, whilst non-current volumes will be filed in the Non-Current section at the off-site storage facilities. Non-current volumes will **NOT** be retrieved routinely for patient attendances, but will be available upon request

3.5.2 Non-current volumes will be flagged with deceased stickers when appropriate, in tandem with the current volume to aid the culling process. All volumes will be transferred to the Deceased storage section

3.6 TRACERING OF MULTIVOLUMES

3.6.1 All current volumes must stay together and be tracered on PAS as one tracer eg VOLS I&II Current

3.6.2 Non-current volumes must be tracered using the multi-volume tracering on PAS. Where a volume contains only nursing notes this will be marked on the tracer.

3.7 NEONATAL CASES

3.7.1 All large Neonatal Unit Intensive Care Charts will be filed separately, stored in the Neonatal Unit for one year, after which they will be stored by the Health Records Department

3.7.2 The current volume of neonatal casenotes must ALSO contain *all* ultrasound and x- ray reports and the most recent complete mount sheets of all other results

3.8 OBTAINING SUPPLIES of CASENOTES

A supply of casenotes folders can be obtained from the Health Records Department, please contact ext [redacted]

3.9 CASENOTES FOR MAJOR INCIDENT

3.9.1 In the event of a major incident, it is important that areas work together to provide a system that supports safe patient care that enables prompt treatment/investigations to be undertaken. In order to do this Ward Support, the Emergency Department and Data Quality will work together to support the urgent processing of patients for emergency treatment/investigations and will pre-register patient casenotes in preparation for any emergency treatment

3.9.2 Ward Support will pre-register 50 sets of casenotes using the number range prefixed with MX (this number range to be used for Major Incidents only), print patient ID labels and place in the plastic wallet within the casenotes

The Admin Manager in the Emergency Department (ED) will ensure all casenotes are complete with the following Major Incident paperwork:

MI patient sheets (yellow)
Blank ED card
ED continuation sheet
Trauma speciality header sheet (WKJ580M)
Pre op/pre procedure nursing checklist (WMJ891L)
Consent form 1 (WMJ850A)
Drug prescription and administration record (WMD870X)
Fluid (addicatiebv drug) prescription sheet (WOS820)
Coma chart
ED nursing documentation sheet (WOS820)
Clinical chemistry and haematology request form
Radiology request form
Blood transfusion form
Labels for all MX pre registered casenotes are in the plastic wallet in the front of the casenotes

3.9.3 The Admin Manager in the Emergency Department (ED) will ensure on a bimonthly basis that the Major Incident paperwork is still applicable and used within the department and that the pre-registered casenotes are stored in the Emergency Department Major Incident cupboard. The Emergency Department will be

responsible for keeping a list of all MX numbers used

Following a Major Incident, a record of all numbers used will be recorded by the ED member of staff co-ordinating the allocation of casenotes (assigned by the ED Admin Manager).

On stand down, a list of patient details and MX numbers used will be given to the Data Quality Department by the member of ED staff co-ordinating the allocation of casenotes, to cross check with the Patient Administration System (PAS).

3.9.4 If a patient is already known to PAS, the Core Support Team will notify Blood Transfusion on ext [redacted] (or bleep [redacted] out of hours) and the Xray Department on ext [redacted] to inform them of the correct patient details and the hospital number to retain. For patients already registered on PAS, casenotes should be merged by the Core Support Team

3.9.5 Once the Major Incident is over all patients will be checked against the Patient First system and any patients not registered will be registered retrospectively. Any duplicates will be managed by the Emergency Department

3.9.6 It will be the responsibility of the Health Records department to ensure that the next batch of MX casenotes to be used are pre-registered. The number range will be given to the Admin Manager in the Emergency Department to be kept with the Major Incident information paperwork in the Emergency Department

APPENDIX 4: REQUESTING AMD PROVISION OF CASENOTES

4.1 It is essential that staff understand the correct procedure for requesting casenotes to enable patient casenotes to be accessed quickly and efficiently, so that patient care is not compromised

4.2 URGENT REQUESTS – EMERGENCY ADMISSIONS

4.2.1 Irrespective of the casenote location, Health Records are responsible for retrieving and delivering the casenotes for emergency admissions. These will be delivered within one hour of the casenotes being requested

4.2.2 This is a 24 hour service:

- 08:00 to 17.00 Monday to Friday – ring ext [redacted] – Select Option 1
- 17:00 to 22:00 Monday to Friday ring ext [redacted] or bleep [redacted]
- Outside of these times bleep [redacted]

4.2.3 If casenotes required out of hours are tracered to an off site location, e.g. Bell House, a temporary folder will be created by Health Records. The original casenotes will be requested and retrieved at the earliest opportunity and merged with the temporary folder

4.3 REQUESTS FOR CASENOTES HELD IN HEALTH RECORD DEPARTMENT LOCATIONS

The Health Records Department is responsible for 3 storage areas within the department: Store, File (Q Library) and Bell House/Industries

The Health Records Department operates a closed library system. Only Health Records staff have access to the Health Records storage areas to retrieve casenotes

4.3.1 **Urgent requests (Not emergency admissions): Maximum 3 sets of casenotes**

- The telephones are staffed from 08:00 to 17:30 Monday to Friday To request casenotes which are required urgently, ring ext [redacted] Option 1
- The following information must be stated slowly and clearly when prompted:

- Your full name
- Your room number
- Your department
- Your extension number
- Name of patient
- Hospital number of patient
- Reason the notes are being requested

Once the casenotes have been retrieved from the storage area, the requester will be notified by telephone that the casenotes are ready for collection. Casenotes are to be collected and signed (printing name) for from the Health Records Reception Desk, on the same day as notified, unless otherwise agreed. Casenotes are not to be left overnight on the Reception Desk. The Health Records Department is locked at 17:15.

Any casenotes not collected by 17:15 will be returned to Store/File and will need to be re-requested.

The person requesting the notes should bring a bag or trolley to the Department in order to collect them

ID must be shown in order to collect casenotes from the Health Records reception Desk. Casenotes will not be provided if ID is not shown

4.3.2 **PULLING LISTS**

Pulling lists must only be created after the appropriate PAS training has been undertaken, delivered by the Clinical Information Systems Training Team. The procedure in the appropriate PAS Training Manual must be followed

A pulling list needs to be created to request casenotes, either:

a. Routinely (completing the mandatory fields on PAS), or
b. Urgently

Urgent pulling lists created before 14:00 will be retrieved and delivered or sent the following working morning

Pulling lists should contain, Ward/Department, Room Number and Extension Number

Do not add to a Pulling List once created and sent to print

Casenotes are delivered by courier to agreed delivery locations within the main hospital

Only casenotes tracered to Store, File or Bell House will be retrieved

Casenotes tracered to Prefile will not be routinely retrieved. The casenotes will need to be re-requested once tracered to Store, File or Bell House

On receipt casenotes from a pulling list must be re-tracered to acknowledge receipt

If a tracer is created, by mistake, instead of compiling a pulling list, Health Records should be contacted immediately – Ext [redacted] Option 4

The pulling list is enclosed with the casenotes when delivered. The list will identify

a) Any casenotes that could not be found (a misfile search is automatically commenced). If the casenotes cannot be found the Missing Notes Coordinator is notified
b) Any casenotes tracered to Bell House. Requests for casenotes tracered to Bell House will automatically be forwarded to Bell House to be retrieved and will follow

4.4 REQUEST FOR CASENOTES NOT HELD IN HEALTH RECORDS DEPARTMENT LOCATIONS

It is the responsibility of the requester to contact the person to whom the notes are tracered to in order to arrange receipt of casenotes that are tracered outside of Health Records storage areas and, where the patient is not an emergency admission

APPENDIX 5: CLINIC PREP STANDARD

5.1 The purpose of this standard is to ensure all patient casenotes and relevant documents are available and correctly prepared in time for the outpatient consultation

5.2 This standard must be followed by all areas preparing casenotes for outpatient appointments

5.3 PROCEDURE

5.3.1 Check casenotes pulled against pre-clinic checklist

5.3.2 Request, timely, any missing casenotes that are tracered to other departments. On receipt of these casenotes, ensure that they are tracered to the clinic

5.3.3 Check off referral letters required. Obtain referral letters as necessary

5.3.4 Affix small patient ID Labels onto outcome slips

5.3.5 Stamp date of clinic and consultant's name on clinical history sheet. If new referral use appropriate coloured header sheet. If follow-up appointment ensure there is at least one blank side of a continuation sheet. All clinical history sheets must have a patient ID label affixed, front and back. Stamp follow-ups as close as possible to either the last entry or letter, leaving no wasted space

5.3.6 All metal clips are replaced with plastic medi-clips

5.3.7 Casenotes should be in a good state of repair. Casenotes in poor condition requiring urgent repair should be dealt with prior to outpatient appointment. Any large volume casenotes should be sent to be split into Current and Non-Current Volumes

5.3.8 Check patient's identification details against referral letter, update PAS and print new patient ID labels as necessary. New label to be affixed to Patient ID Sheet, crossing through the old label and placing the new label so that both the old and new label are visible (destroy any old labels). Minimum of 1 full set of labels must be available in plastic wallet. Out-of-date labels must be discarded into confidential waste

5.3.9 A temporary folder should be created by Health Records only when original casenotes are genuinely unavailable (not while awaiting casenotes to be sent by secretary etc)

5.3.10 Store prepared casenotes in terminal digit order on appropriate shelf in readiness for the clinic. Clinics should be labelled with clinic code and appointment date

5.3.11 Additions to clinics will be notified through an email – ensure that speciality mailbox is checked regularly several times a day, daily

5.3.12 For casenotes that are needed in the Community Hospitals (including Heavitree) ensure that clinics are sent out timely

5.3.13 Before putting clinics out, on or before the allotted times, do one final check ensuring that all notes are available for the clinic, have been prepared correctly and are tracered. Referral letters should be ticked off on the final sheet that goes out with the clinic, along with any messages relating to any notes that may be missing for whatever reason (ie Consultant secretary bringing them to clinic)

Ensure that any problems are communicated to the Team Leader or Supervisor timely

5.3.14 Key to colour coded front sheet

GENERAL MEDICINE	Green
ENT	Blue
GENERAL SURGERY	Red
GYNAECOLOGY	Orange
DERMATOLOGY	Brown - unlined
TRAUMA	Yellow stripes
NEUROLOGY	Black
RADIOTHERAPY	Black stripes
ORTHOPAEDIC	Yellow
OPHTHALMOLOGY	Blue

5.4 MONITORING AND AUDITS

5.4.1 The Health Records Supervisor audits a random selection of prepped clinics on a regular basis. The results of the audit are circulated to the Head of Records Management and Administration Services Manager for Health Records, who use this information to highlight issues and areas for improvement, such as identifying training needs

APPENDIX 6: SECURE HANDLING, TRACKING AN D TRANSPORTATION OF CASENOTES

6.1 SAFE AND SECURE TRANSPORTATION OF CASENOTES

6.1.1 It is important staff understand the correct procedures for the despatch, transportation and tracking of casenotes, and the importance of ensuring this is done safely and securely in order to maintain confidentiality and prevent loss of information

6.1.2 Secure methods of transportation should always be used. On no account should unsecure or inappropriate bags or containers be used, such as Patient Property, Confidential Waste or Supermarket bags or Black Bin liners, to transport them

6.2 MOVEMENT OF CASENOTES WITHIN PATIENT – WITHIN THE TRUST

6.2.1 Casenotes of patients travelling between wards and departments should be transported by a member of staff or volunteer. The casenotes must be transported in a sealed envelope or bag. Secure Bags are available to order on the Trust's electronic ordering system EROS

6.2.2 On no account should patients be asked to transport their own notes within or across Trust sites. In exceptional circumstances only, where a member of staff or volunteer is not available, casenotes must be placed in a lockable bag for the patient to transport within the building, the use of a sealed envelope is not appropriate in this case

6.2.3 If a patient is being moved within the hospital by wheelchair the notes should be placed in a sealed bag and can be held by the patient, if they are being transported by bed within the hospital, they must be placed face down on the bed, so the name is not visible. The Head of Records Management should be contacted if advice is needed

6.2.4 The tracer must be updated immediately to identify the casenotes destination.
If access to the tracer system is not available, during normal working hours the Health Records Department on ext [redacted] should be contacted to tracer the casenotes, outside normal working hours Ward Support must be contacted on bleep [redacted] for assistance

6.3 MOVEMENT OF CASENOTES WITH PATIENT – OUTSIDE THE TRUST

6.3.1 Original casenotes are only sent to a restricted number of locations, see 6.10

6.3.2 If sending original casenotes to an agreed location, the casenotes must be

- Carried by the ambulance escort / hospital car driver.
- Transported in a sealed envelope marked clearly with the patient's destination.
- The tracer must be updated immediately to identify the casenotes destination.
- If access to the tracer system is not available, during normal working hours the Health Records Department on ext [redacted] should be contacted to tracer the casenotes, outside normal working hours Ward Support must be contacted on bleep [redacted] for assistance
- A slip should be enclosed with the casenotes indicating the appropriate return address. This is inserted into the pocket on the front of the casenotes.

6.3.3 If a patient is transferred to a location that does not receive original casenotes, the ward clerk is responsible for ensuring appropriate documentation is copied in advance of the transfer. Out of hours, Ward Support is available on bleep [redacted] to copy the appropriate documentation. The photocopies must be

- Bound either by stapling or treasury tags.
- Carried by the ambulance escort / hospital car driver.
- Transported in a sealed envelope marked clearly with the patient's destination

6.4 MOVEMENT OF CASENOTES WITHOUT PATIENT – OUTSIDE THE TRUST

6.4.1 If a patient has an outpatient appointment at a Peripheral Clinic at an approved location, under a RDE Clinician, it is essential for patient care that the casenotes are available. Casenotes must be transported securely and where possible, the courier service from the Trust must be used. Casenotes must be tracered appropriately

6.4.2 If an outpatient clinic is to be held in a Peripheral location, the Directorate must ensure a risk assessment is undertaken to ensure adequate security of the casenotes, whilst at the location. Advice can be sought from the Information Governance Manager

6.5 INTERNAL POST

6.5.1 When sending casenotes by internal post, the following must be adhered to:

- Casenotes must be tracered to the new location. If access to the tracer system is not available, during normal working hours the Health Records Department on ext [redacted] should be contacted to tracer the casenotes, outside normal working hours Ward Support must be contacted on bleep [redacted] for assistance.
- Casenotes must be transported in a sealed envelope or zipped bag.
- The envelope/bag must be clearly addressed with the name of the recipient, room number, department and hospital if appropriate
- If an envelope has been used previously, the previous addresses must be obliterated
- The envelope/bag must be left in a designated location for the postman/courier to collect

6.6 REQUESTS FOR URGENT TRANSPORTATION

6.6.1 Requests for urgent transportation must be made through Health Records. Advice will be provided regarding options available and transportation will be organised as appropriate

6.6.2 A courier may be requested by Health Records when no other means of transportation is viable, and casenotes are required by health professionals to enable delivery of care, i.e. when a patient is either an inpatient or an outpatient appointment is due to take place

6.6.3 Casenotes transported by courier must be placed in a sealed envelope, which is clearly addressed and marked confidential. The courier must show ID, and sign for the casenotes

6.6.4 Casenotes must be tracered appropriately

6.7 USE OF TROLLEY OR HAND HELD

6.7.1 Casenotes transported by hand must be placed in an envelope or bag, in order to maintain patient confidentiality and ensure no loss of documentation

6.7.2 Where casenotes are transported by trolley, patient names must not be visible. In circumstances where casenotes are transported outside, the trolley must be covered to protect from the weather

6.7.3 Casenotes must be stacked carefully when being transported by trolley, to ensure casenotes are not damaged in transit and that documentation cannot be lost

6.7.4 Casenotes must not be left unattended at any time

6.8 PROVIDING PHOTOCOPIES OF CASENOTES

6.8.1 If a request is made for access to casenotes that is not a location identified in 6.10, the original casenotes must not be sent

6.8.2 All requests for access to casenotes (from other hospitals, patients, solicitors etc) must be made through the Information Governance Support Office, where specific procedures are followed. See Appendix G 'Requests for Access to Personal Data)

6.8.3 Full contact details (i.e. name, telephone number and hospital address) must be enclosed with any photocopies of casenotes provided

6.8.4 All envelopes sent externally must be strong, clean, addressed clearly and marked confidential

6.9 CASENOTES REQUIRED BY THE EXETER NUFFIELD HOSPITAL OR PRIVATE ROOMS

6.9.1 Casenotes required by the Exeter Nuffield Hospital or private rooms of consultants employed by the Trust must be placed in a sealed envelope that is clearly addressed. The casenotes can be sent either internally through the consultant's NHS secretary or left for collection at the General Enquiries desk on the main concourse. ID must be shown when casenotes are collected, and the casenotes signed for

6.9.2 The casenotes must be tracered appropriately, e.g. 'PRIVATE RMS, JFT SEC, VIA NHS SEC, TEL. NUMBER', or 'EXETER NUFFIELD, JFT SEC, FOR COLLECTION FROM GENERAL ENQUIRIES, TEL. NUMBER'

6.9.3 A slip should be enclosed with the casenotes indicating the appropriate return address. This should be inserted into the plastic pocket on the front of the casenotes

6.10 HOSPITALS TO WHICH WE SEND RD&E CASENOTES

Hospital	Address	Associated Wards	Telephone numbers
Axminster Hospital	Chard Street, Axminster EX13 5DU		01297 630400
Bideford Hospital	Abbotsham Road, Bideford EX39 3AG	3 wards + reablement	01237 420200
Blake Social Services	Northgate, Bridgwater, TA6 3HF		01278 431111
Budleigh Salterton Hospital	East Budleigh Road, Budleigh Salterton EX9 6HF		01395 442020
Crediton Hospital	Western Road, Crediton EX17 3NH		01363 775588
Culm Valley Health Centre	Willand Road, Cullompton, EX15 1EP		01884 831300
Dame Hannah Rodgers School	Woodland Road, Ivybridge, Plymouth PL21 9HQ		01752 892461
Dawlish Community Hospital	Barton Terrace, Dawlish EX7 9DH		01626 868500
Dene Barton Community Unit	Unit 9 Dene Road, Cotford St Luke, Taunton T!$ 1DD		01823 431930
Ellen Tinkham School	Hollow Lane, Pinhoe, Exeter EX1 3RW		01392 467168
Exmouth Hospital	Claremont Grove, Exmouth EX8 2JN	Dewdney Reablement Unit Doris Heard ward Geoffrey W illoughby ward Main switchboard	01395 282021 01395 282010 01395 282014 01395 279684
Franklyn Hospital	Franklyn Drive, St Thomas, Exeter EX2 9HS	Westleigh ward Rougemont ward	01392 208404 01392 208417
Highfield House	Vicarage Road, Barnstaple, EX32 7BH		01271 341500
Holsworthy Hospital	Dobbles Lane, Holsworthy EX22 6JQ	Wards + reablement	01409 253424
Honeylands Children's Centre	Pinhoe Road, Exeter EX4 8AD		01392 207777
Honiton Hospital	Marlpits Road, Honiton EX14 2DE		01404 540540
Langdon Hospital	Exeter Road, Dawlish EX7 0NR	Avon House Leander Unit Prentice House (Admin) Butler Clinic	01626 884428 01626 884557 01626 888372 01626 888371
Mardon Centre	Wonford Road, Exeter EX2 4UD		01392 208580 Fax 662929

Mayfield School	Moor Lane, Torquay TQ13 2AL		01803 328375
Melrose Unit	Tiverton and District Hospital, Kennedy Way, Tiverton, Devon, EX16 6NT		01884 259171

Millwater School	Honiton Bottom road, Honiton EX14 2ER		01404 43454
Moretonhampstead Hospital	Ford Street, Moretonhampstead TQ13 8LN		01647 440217
North Devon District Hospital	Raleigh Park, Barnstaple EX31 4JB		01271 322577
Nuffield Hospital (Exeter only)	Wonford Road, Exeter EX2 4UG		01392 276591
Okehampton Community Hospital	Cavell Way, Okehampton EX20 1PN		01837 658000
Ottery St Mary Hospital	Keegan Close, Ottery St Mary EX11 1DN		01404 816023
Pathfields School	Abbey Road, Barnstaple, EX31 1JU		01271 342423
Penrose School	Albert Street, Bridgwater TA6 7ET		01278 431075
Royal Academy for Deaf	50 Topsham Road, Exeter EX2 4NF		01392 267023
Seaton & District Community Hospital	Valley View, Seaton EX12 2UU		01297 23901
Selworthy School	Priors Wood, Taunton, Somerset TA2 8HD		01823 284970
Sidmouth (Victoria) Hospital	Sidmouth EX10 8EW		01395 512482
South Petherton Hospital	Bernard Way, South Petherton, Somerset, TA13 5EF		01460 243000
South Molton Community Hospital	Widgery Drive, South Molton EX36 4DP	Hugh Squire ward	01769 572164
Stowford Lodge	Sedemuda Road, Sidmouth EX10 9YA		01395 513200
Stratton Hospital	Hospital Road, Stratton, Cornwall, EX23 9BR	XRS for Hosworthy	Fax012 8081 3298577 500166 01
Teignmouth Hospital	Mill Lane, Teignmouth TQ14 9BQ		01626 772161
The Bungalow	Honiton Hospital, Marlpits Road, Honiton EX14 2DE		01404 540546
The Avalon School	Brooks Road, Street, Somerset, BA16 OPS		01548 443081
Tiverton Hospital	Kennedy Way, Tiverton, Devon, EX16 6NT		01884 235400
Vranch House School & Centre	Pinhoe Road, Exeter EX4 8AD	Reception	01392 468333
West of England School	Topsham Road, Countess Wear, Exeter E2 6HA		0011339922 446585425800
Whipton Community Hospital	Hospital Lane, Whipton, Exeter, EX1 3RB	Budlake ward	01392 208338
Withycombe Health Centre	89 Withycombe Village Road, Exmouth, EX8 3AE		0011339925 220283272835
Wonford House Hospital	Dryden Road, Exeter EX2 5AF	Medical Records	01932 403435/6

APPENDIX 7: REQUESTS FOR ACCESS TO PERSONAL DATA

7.1 Individuals have the right of access of information held about them. The following provides guidance on the types of requests that may be received from patients or staff

Live patients - All requests for access to live patients' information must be processed in line with the Data Protection Act 2018

Deceased patients - All requests for access to information of deceased patients must be processed in line with the Access to Health Records Act 1990

Staff - All requests for access to personnel files must be processed in line with the Data Protection Act 2018.

7.2 WHO CAN ACCESS PERSONAL DATA

- Other hospitals that require information in order to treat the patient.
- The data subject (the individual concerned).
- A parent/guardian on behalf of their child. Access will be granted by the health professional in charge of the clinical care, if deemed in the best interest of the child.
- A person authorised by the data subject to apply on their behalf, e.g. relative, person holding Power of Attorney, solicitor etc.
- Where a patient has died, the patient's personal representative or someone applying with the personal representative's consent.
- Where a patient has died, anyone who may have a claim arising out of the patient's death or someone applying on his or her behalf

7.3 APPLICATION PROCESS

7.3.1 All requests for access to personal data will be processed by the Information Governance Team following the Subject Access Request (SAR) Policy, except in circumstances when litigation against the Trust is indicated. In this instance the request will be forwarded to the Legal Liaison Department.

7.3.2 A record of each request is logged on the appropriate Information Governance database

7.3.3 The request for access must be made in writing. Identification and proof of authorisation must be provided, except when information is being requested by another hospital for treatment

7.3.4 The applicant has the option to either attend the hospital to view the original record or receive copies of that record. The copy will be provided in an electronic form unless requested otherwise.

7.3.5 A 'Copying of Records' form is filed in the casenotes directly behind the Patient Identification Sheet or at the front of the personnel file. The form is used to record the date access has taken place, who has accessed the information and what information has been provided/viewed

7.3.6 All photocopies of records sent by external postal delivery must be sent by 'Recorded Delivery' or 'International Signed For', via the Trust Post Room. Envelopes must be strong, clean, addressed clearly and marked confidential

7.3.7 The data requested must be made available within the following timeframes

- Other Hospitals for treatment – IMMEDIATELY
- Live data subjects - within 1 month of request
- Deceased Patients - within 40 days of receipt of written request, or within 21 days if entries have been made in the record in the previous 40 days

7.4 EXCEPTIONS

Access will not be given in the following circumstances

- Where the holder of the record is not satisfied that the applicant is acting with the data subject's / data subject's legal representatives / next of kin's permission.
- Where the health professional responsible for the clinical care of the patient believes that access would be likely to cause serious harm to the physical or mental health of the patient or any other individual.
- Where the information in the record relates to another person, or was provided by another person (third party), who is not the data subject or applicant, but who may be identified from the record. The individual identified can give permission for the information to be disclosed. Third party information does not apply to health professionals.
- If the data subject had either provided the information in the expectation it would not be disclosed to the applicant or had indicated it should not be disclosed. In the case of deceased patients, where there is information that suggests the deceased patient would not have wanted records disclosed

7.5 EXPLANATION OF ENTRIES

Once access has been provided, the applicant will be able to request further information by way of an explanation of the entries, from an appropriate health professional

7.6 INACCURATE RECORDS

Following access a data subject/representative may request that a correction is made to an entry, this application must be made in writing to the Head of Records Management. If the holder of the record (in conjunction with the health professional/manager concerned) is satisfied that the information is inaccurate, then a correction may be made, but the original entry will not be obliterated. If the holder is not satisfied that the information is inaccurate, then a note will be made in the record to show the applicant's view of the matter alongside the entry concerned.

7.7 INFORMAL ACCESS

Applicants can verbally or informally request access to their records from the health professional concerned. It is the responsibility of the health professional to decide whether the notes made by themselves and members on their team can be viewed. One health professional cannot authorise access to information created by another health professional.

APPENDIX 8: SHARING PATIENT IDENTIFIABLE INFORMATION IN A MAJOR INCIDENT

8.1 **This must be read in conjunction with the** Disclosure of Information to the Police Procedure

This Procedure is relevant to the Major Incident Control Team, On-Call Director, On-Call Manager, Site Management. It should be read in conjunction with the Disclosure of Information to the Police Procedure

8.2 PURPOSE OF THE PROCEDURE

8.2.1 Organisations co-ordinating the response to a Major Incident may wish to contact people in an affected area to provide information or support. For example, if a large number of people had to be evacuated from an area, the Police and Local Authorities may need information about people who would need wheelchair accessible transport

8.2.2 This procedure outlines the processes to be followed to share patient identifiable information of specified patient groups during a major incident on request of a Multi-Agency Strategic or Tactical Co-ordinating Group, or a Vulnerable People Co-ordination Group set up by one of the aforementioned Groups

8.2.3 Under the Civil Contingencies Act 2004 (the CCA), the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) is classified as a Category 1 Responder and has a duty to maintain arrangements to warn the public and to provide information and advice to the public if an emergency is likely to occur or has occurred.

8.2.4 The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 place a duty on Category 1 and 2 responders to share information on request with other Category 1 and 2 responders in the planning, response and recovery stages of an emergency.

8.2.5 The Trust is a member of the Devon, Cornwall and Isles of Scilly Local Resilience Forum (LRF) who support the Trust with emergency planning, response and recovery. Refer to the Data Protection and Sharing – Guidance for Emergency Responders for further information.

8.3 DUTIES AND RESPONSIBILITIES OF STAFF

- Incident Director – Decide if it is appropriate to share patient information without consent. If necessary and time allows this will be in consultation with the Trust's Caldicott Guardian and the Information Governance Manager

- Caldicott Guardian – Under normal circumstances, responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. In a Major Incident, if time allows, support the Incident Director in deciding if it is appropriate to share patient information. Record information shared on the Caldicott Log

- Planning and Preparedness Manager – Responsible for the creation and review of the Sharing Patient Identifiable Information in a Major Incident Procedure and maintenance of patient group lists

- Nominated Person – Person nominated by the Incident Director to obtain patient information and once approved by the Incident Director to send to requesting organisation. This is likely to be a Site Practitioner or On-Call Manager but could be an Administrative, Clinical or other Service Manager

8.4 PROCESS FOR SHARING INFORMATION

Following a request from a Multi-Agency Strategic or Tactical Co-ordinating Group, or a Vulnerable People Co-ordination Group set up by one of the aforementioned groups, the procedure below should be followed:

PROCESS FOR SHARING INFORMATION

ACTION	SUPPORTING INFORMATION
INCIDENT DIRECTOR	Executive Director leading the incident response (or On-Call Level 1 if the Trust has not declared a major incident)
Decide if it is appropriate to share patient information without consent	If time allows consult with the Trust's Caldicott Guardian and the Information Governance Manager
Decide the amount of information required to be shared ***Caldicott Principles:*** ***1*** ***-*** *Justify the purpose for using confidential information* ***2*** ***-*** *Only use it when absolutely necessary* ***3*** ***-*** *Use the minimum that is required* ***4*** ***-*** *See below* ***5*** ***-*** *See below* ***6*** ***-*** *Understand and comply with the law*	Is it in the best interest of the individual(s) concerned? Will sharing information potentially reduce the risk of harm to the individual(s)? Is it allowed under the Data Protection Act 2018? • Under Schedule 2 personal information can be shared where this is necessary to protect the person's vital interests • Under Schedule 3 sensitive information can be shared without consent where this is necessary to protect the person's vital interests What is the minimum amount of information necessary to reduce the risk of harm to the individual(s)?

Ensure requesting organisation or Vulnerable People Co-ordination Group has provided a written request ***Caldicott Principles:*** ***4*** ***-*** *Access should be on a strict need-to-know basis* ***5*** ***-*** *Everyone must understand his or her responsibilities*	Written request to include: The type of incident The reason for the information request The type of people who may be considered vulnerable The area affected and post-code(s) The minimum level of information required Which other organisations will need to have access Assurance that it will: Hold the information securely Use it for the purposes of safeguarding the safety of those individuals
	Not keep the information any longer than is required for this purpose Not share with third parties without written consent Return the information once it is no longer required or destroy the information and notify the Trust
Nominate a person to carry out actions below	This is likely to be a Site Practitioner or OnCall Manager but could be an Administrative, Clinical or other Service Manager
Provide the nominated person with the post code area(s) that patient information is required for and the patient information required, i.e. Home Haemodialysis Home Oxygen Mobility	Request from requesting organisation or Vulnerable People Co-ordination Group
Nominated Person	This is likely to be a Site Practitioner or OnCall Manager but could be an Administrative, Clinical or other Service Manager
If during normal working hours	Contact specialities for details of potentially vulnerable patients in affected area: • Hospital at Home (H@H) - H@H Community Matron or H@H Ward Whiteboard (via Site Practitioner) • Pregnant women - Maternity Renal - • Home Haemodialysis • Respiratory Medicine - Home Oxygen Exeter • Mobility Centre – Mobility

If out of normal working hours:	**Follow procedures below**
H@H Pregnant women	H@H - H@H Ward Whiteboard via Site Practitioner Pregnant women – Contact Midwifery Manager
Home Haemodialysis Home Oxygen Mobility	Locate and open the spread-sheet located on the Site Management Shared Drive • Password – Refer to copy of [redacted] • Spread-sheet has four worksheets Instructions

	Home Haemodialysis Home Oxygen Mobility
Before editing, save as a new file on the Site Management Shared Drive file	Saved spread-sheet will remain password protected (Password as above)
For home haemodialysis patients	If data not required, delete worksheet If data required: Spread-sheet contains: • Patient name, number, address and post code • Patients sorted in post code order • Delete details of patients not in affected post code area(s) • Save changes
For patients on home oxygen	If data not required, delete worksheet
	If data required: • Spread-sheet only contains Patient Number and post code • Details sorted in post code order • Delete details of patients not in affected post code area(s) • To find name and address, search on PAS using Patient Number • Check patient not deceased • Exclude patients under 18 • Enter name and address of patients in blank columns or print details from PAS

For patients registered with Exeter Mobility Centre	If data not required, delete worksheet If data required: • Spread-sheet contains patient name, number, address, postcode, telephone numbers and level of mobility • Details sorted in post code order • Delete details of patients not in affected post code area(s)
Save amended spread-sheet	Saved spread-sheet will remain password protected: (Password as above)
Review patient information to be sent and the method for sending the information with the Incident Director	Incident Director to record decision to share information in Incident Chief Executive's Major Incident Log
Once approved by the Incident Director, send patient information to the requesting organisation	Patient information must only be sent using approved secure systems e.g.: NHS Mail to other NHS Mail account
	NHS Mail to Devon and Cornwall Police emails with the following suffix: @devonandcornwall.pnn.police.uk • NHS Mail to Local Authority emails with the following suffix: *@LocalAuthority*.gcsx.gov.uk • Safe Haven fax procedures
Record what information has been shared	Details must be recorded on form DP2 (See Appendix 2 of the Health Records Procedure Notice PN32)
As soon as the information is no longer required, the requesting organisation must provide written assurance to the Incident Director that all copies of the information provided has been returned to the Trust or destroyed. This may be by email. If information has been destroyed, the requesting organisation must provide written conformation of the incident Director that this has been carried out and hoe the information has been destroyed. This may be by email	Details must be recorded and sent to the Trust's Information Governance Manager to retain for any post- incident review or enquiry

APPENDIX 9: DESTRUCTION AND RETENTION OF CASENOTES

9.1 PURPOSE

To ensure staff understand the correct procedure for destroying casenotes. To ensure staff are aware of the retention periods for casenotes, and the correct procedure to follow when requesting that casenotes be preserved for longer than the minimum retention period

9.2 CASENOTES COVERED BY PROCEDURE

This procedure applies to the main RD&E record used Trust wide, and not any other personal health records held elsewhere

9.3 REASON FOR DESTRUCTION OF CASENOTES

In order to provide an efficient retrieval and filing system it is vital to maintain sufficient space within the Health Records storage areas. It is necessary, therefore, to control the number of casenotes, whilst ensuring clinical requirements for information is maintained. This is achieved through a number of measures, one of which is the destruction of casenotes

9.4 RETENTION SCHEDULE

This procedure has been written in line with the Department of Health's 'Records Management: NHS Code of Practice', in consultation with the Trust's Medical Directors. The Code of Practice is a guide to the standards of practice required in the management of NHS records, based on current legal requirements and professional best practice. The Code of Practice contains details of the recommended minimum retention period for each type of NHS record. The is included within the Trust's Record Management Policy as the Retention and Destruction Schedule. NHS Digital Records Management Code of Practice for Health and Social Care 2016

In accordance with the guidance 'Records Management: NHS Code of Practice', the minimum retention periods are calculated from the beginning of the year after the last date on the record.

9.4.1

TYPE OF RECORD	PERIOD FOR RETENTION
Children and young people	Ror 2eta6i$_{th}$n iuntf yoil theung ppearsontient' sw 2as 17 5th birthat day conclusion of treatment, or 8 years after death.
Obstetric Records	25 years after the birth of the last child
Mentally disordered persons (within the meaning of any Mental Health Act) with a recorded attendance with a psychiatrist	20 years, or 8 years after patient's death if sooner
Oncology (patients who have received Radiotherapy or chemotherapy at the RD&E)	NB: Radiotherapy Notes are retained indefinitely. The Exeter Oncology Centre is responsible for the storage of Radiotherapy Notes.
Renal (patients who have received renal	8 years after death
dialysis, kidney transplant or kidney donor)	
Orthopaedic (patients who have received the following treatment: spinal operations, joint replacements and joint reconstructions or have had congenital deformities of hip / feet)	8 years after death 10 years following a joint replacement
Anaesthetic Hazard	8 years after death
All other health records	8 years after last attendance

Genito-Urinary casenotes:

TYPE OF RECORD	PERIOD FOR
Records of patients who have come to the department as a result of sexual abuse	20 years **R**after**ETE** th**N**e **TION**atten dance
Records of patients with a diagnosis of syphilis	20 years, or 8 years after death if sooner
Records of patients with HIV	8 years after death

Clinical Trials records

TYPE OF RECORD	PERIOD FOR
Trial Subject's Medical Files/Health Record	5 years a**R**fter co**ETEN**n**T**cl**ION**usion of trial (non-drug) unless exceeded by the retention period above.
Trial Subject's Medical Files/Health Record	15 years after conclusion of drug trial unless exceeded by the retention period above.

9.4.2 Where clinicians are acting as investigators for clinical trials, it is their responsibility to ensure that the appropriate documentation relating to a particular trial is safely retained, independent to the casenotes, where the time limits for the trial fall outside the retention schedule time periods

9.4.3 The responsibility to retain casenotes beyond the National and Trust requirements lies with the health professional. Where it is deemed clinically necessary to retain particular casenotes which do not fall within either the Department of Health retention categories or Trust retention categories, the health professional in charge of the care of the patient will be required to complete a 'Retention of Casenotes Request Form' Annex B returning it with the casenotes to the Destruction and Retention Officer, via Health Records, whereupon PAS will be flagged (an R will appear next to the RD&E number).

9.5 PROCEDURE FOR DESTROYING CASENOTES

9.5.1 The destruction of casenotes should only be undertaken by designated and trained Health Records staff

9.5.2 Casenotes meeting the criteria for destruction will be identified by PAS, and a list will be produced. A filter excludes all the categories of casenotes stated above (with the exception of anaesthetic hazards)

9.5.3 The casenotes identified on the Destruction Culling List are retrieved from file. A record is made on the Destruction Culling List of the casenotes pulled

9.5.4 Casenotes are checked for an Anaesthetic Hazard. Casenotes with an Anaesthetic Hazard sticker on the front or inside cover of the casenotes are not pulled from file and an explanatory note is recorded on the Destruction Culling List

9.5.5 The casenotes are stored securely in Destruction Boxes until shredded

9.5.6 Casenotes retrieved from file are flagged as Destroyed on PAS. The tracers 'AWAITING DESTRUCTION' and 'DESTROYED' are automatically created. A flag 'DESTROYED RD&E' appears on the Patient Index Details screen (N1)

9.5.7 A record is made on the Destruction Culling List that the casenotes have been destroyed on PAS

9.5.8 Casenotes with Anaesthetic Hazard stickers are retained, following steps below

9.6 PROCEDURE FOR RETAINING CASENOTES NOT FILTERED BY PAS

9.6.1 The retention of casenotes should only be undertaken by designated and trained Health Records staff

9.6.2 Where it is deemed clinically necessary to retain casenotes for longer than the periods identified above, the health professional in charge of the care of the patient can request for the casenotes to be retained

9.6.3 A Retention of Casenote form can be found within the Destruction and Retention of Casenotes Procedure and should be completed and sent, with the casenotes, to the Destruction and Retention Officer, via Health Records. The form must stipulate the reason for retention and the length of time the casenotes will need to be retained

9.6.4 The Destruction and Retention Officer will retain the casenotes on PAS. A letter 'R' will automatically appear on the Patient Index Details screen (N1) adjacent to the RD&E hospital number, to signify that the casenotes have been retained. This action ensures the casenotes will not appear on any further Destruction Culling Lists

9.6.5 The 'Retention of Casenotes Request Form' will be filed in the 'Retention of Casenotes' file, which is held by the Destruction and Retention Officer

9.6.7 All casenotes retained at the request of a health professional will be reviewed on an annual basis. The Destruction and Retention Officer will contact the health professionals concerned to enquire whether the retention is still required

9.7 INFORMATION AVAILABLE AFTER DESTRUCTION

- The patient will remain on the PAS Master Index, retaining their original hospital number.
- The patient's attendance history will be available on PAS.
- Diagnostic and operative coding, where applicable, will be available on PAS.
- Patient information stored on PAS will be archived as at present.
- Operation notes, discharge summaries, correspondence may be available other IT systems eg CDM.

9.9 RE-ATTENDANCE

9.9.1 If a patient re-attends after their casenotes have been destroyed, the patient will be issued with a new casenote folder, but will retain their original hospital number. The Process for Creating Casenotes (Appendix 3) should be followed when issuing a new casenote folder

9.9.2 An 'OLD CASENOTES DESTROYED' sticker is attached to the inside front cover of the casenotes, in the top left corner

9.9.3 A summary of the attendance history can be printed from PAS and filed in the casenotes for reference

9.9.4 The casenote should be tracered on PAS and once done so the 'DESTROYED RD&E' flag will disappear from the Patient Index Details screen (N1), and a letter 'D' will automatically appear adjacent to the RD&E hospital number to signify that the previous casenotes were destroyed

9.10 TRANSITORY DOCUMENTS WITHIN THE CASENOTES

The Department of Health states that 'it is not necessary to keep every single piece of paper received in connection with patients and Health Authorities should determine, in consultation with their health professionals, their policy with regard to the elements which should be regarded as a permanent constituent of the record and those elements of a transitory nature which may be discarded as their value ceases'. Currently, the intention is not to destroy any documents prior to overall destruction of casenotes, but this is to be reviewed shortly in consultation with the health professionals. A suggested list of transitory documents can be seen below:

Temperature chart
Blood pressure chart
Toxaemia chart
Peak flow chart
Fluid balance chart
Intravenous chart
Antibiotic chart
Anticoagulant chart
Peritoneal dialysis chart
GP drug treatment chart

9.11 SCANNED PAPER RECORDS

Where the patient's casenotes have been scanned, the information will be available electronically and must be viewed electronically. The paper copy will be destroyed within 3 months of the casenote being scanned. If the patient re-attends a new casenote folder will be raised using the existing hospital number. On no account should information from the scanned record be printed off and put into a casenote folder.

9.12 Retention of Casenotes Form

Royal Devon and Exeter NHS
NHS Foundation Trust

HEALTH RECORDS DEPARTMENT

RETENTION OF CASENOTES REQUEST FORM

Only complete this form if you require the casenotes to be retained **BEYOND** the timescale agreed in the Trust's Destruction and Retention of Casenotes Procedure.

Affix patient ID label here or complete:

Surname: ……..…Forename: ……..…..…

Date of Birth: ……..…….. NHS number: ……..…….

Hospital number: ……..……...……

Reason for retention: .....

Length of time to be retained: .....

Health Professional in charge: .....

Signed: .....

Date: .....

PLEASE RETURN FORM (WITH CASENOTES) TO: Destruction and Retention Officer, Health Records, RD&E (Wonford).

APPENDIX 10: DISCLOSURE OF INFORMATION TO THE POLICE PROCEDURE POLICE REQUESTS FOR INFORMATION

10.1 GET ASSISTANCE

10.1.1 Always refer to a senior member of staff prior to disclosure of information to the Police. Authorisation to disclose information needs to be sought. The request must be referred to the Information Governance Manager or the Caldicott Guardian. Out of hours contact the Site Practitioner

10.2 ENSURE THE REQUEST IS MADE IN WRITING

10.2.1 Requests from the Police for person identifiable information must always be made in writing. Such requests can be made under Section 29 (3) of the Data Protection Act 2018 and are made using a Police Form 277 Data Request Form. Note that other Police forces will have similar forms. They are normally referred to as Personal Data Request forms or Data Protection Act Request forms

10.2.2 All forms should be emailed to the Trust's dedicated email address for police enquiries: rde-tr.policequeries@nhs.net. This is managed by the Information Governance Office. Out of normal office hours the Ward Support team have access to the account

10.2.3 Forms given by hand should be delivered to the Information Governance Office, Q127 during normal office hours. During evenings, nights and weekends the form should be referred to the Site Practitioner

10.3 PATIENT CONSENT

Where possible, the patient's consent to release information should be sought. However, there are times when this may not be appropriate or possible. For example, the patient is unconscious or has absconded, or has been discharged from the care of the organisation, or where gaining consent is likely to result in further incidents or risk. The duty of care requires the Trust to consider whether the patient is capable of making an informed decision. There may also be occasions when a patient has died. Clearly, patient consent no longer applies. However, information about the person is governed by the Access to Health Records Act 1990. Enquiries concerning deceased patients should follow the same procedures as those detailed below

10.4 POLICE REQUESTS FOR INFORMATION BY TELEPHONE OR IN PERSON

When a member of Trust staff receives a telephone call from the Police or a request from a Police Officer in person, the following procedures should be followed:

During daytime office hours Mondayto Friday (08:30 to 17:00)
Transfer the call or refer the Officer to the Information Governance Office [redacted]
Evenings, nights and weekends
Inform the caller or Officer that Form 277 must be completed and emailed, faxed or delivered to the addresses detailed at 10.2.4. If necessary, transfer the call to Ward Support on ex [redacted]

10.5 COURT ORDERS

10.5.1 Personal information requested under a Court Order must be provided immediately under the supervision of the Information Governance Office, Caldicott Guardian or the Site Practitioner. Failure to comply with such an Order is contempt of Court

10.5.2 Verification of a Court Order must be sought from the Information Governance Office, Caldicott Guardian. During, evening, nights and weekends contact the Site Practitioner

10.5.3 These requests must be forwarded/ notified to the Caldicott Guardian, for inclusion in the Caldicott log. This **must not** be recorded in the patient's health records

10.6 WHERE TRUST STAFF APPROACH THE POLICE, KNOWING OR STRONGLY SUSPECTING THAT AN OFFENCE HAS BEEN COMMITTED

10.6.1 Staff have a duty to each other to minimise risks and working hazards and managers have a duty to ensure that their staff are not put at unnecessary risk. This may include reporting information about patients or service users to line managers, who may then take this action forward to reporting to police

10.6.2 Staff who report this type of information to the Police must ensure it is reported as a Datix incident and to their line manager. Out of hours, the Site Practitioner must also be informed

10.7 WHEN TRUST STAFF APPROACH THE POLICE BECAUSE THEY BELIEVE A CRIME MAY BE COMMITTED IN THE FUTURE

10.7.1 If staff suspect that a patient, or visitor, is in possession of firearms, other weapons or drugs they should contact the Trust's Security Department immediately, providing whatever details are known, on extension [redacted] The Police must also be contacted via 9/999

10.7.2 It is the responsibility of the Trust's Security staff to maintain observation of the patient or visitor, passing any searches onto the Police who are backed by appropriate legislation. Safety for all staff, patients and visitors is always paramount

10.7.3 Details of any personal information passed to the Police must be sent to the Information Governance Office

10.7.4 Staff who report this type of information to the Police must ensure it is reported as a Datix incident and to their line manager. Out of hours, the Site Practitioner must also be informed

10.8 ARCHIVING ARRANGEMENTS

The original of this standard operating procedure will remain with the Information Governance Manager in the Health Records Department of the Information Governance Department, Finance & Business Development Division.
An electronic copy will be maintained on the Trust Intranet (IaN), P – Policies – D – Disclosure. Archived copies will be stored on the Trust's "archived policies" shared drive, and will be held for 10 years

APPENDIX 11: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All Staff who handle Health Records in the course of their duties.
The key changes if a revised policy/strategy	Health Records Procedures have been reviewed and amalgamated and are now appendices
The key objectives	This policy is intended to ensure that the Trust's management of Health Records supports the Trust in its strategic objectives and the delivery of safe patient care. The Trust will ensure that Health Records are kept confidential, accessed only by those that need it; the information contained within them is accurate, up to date and in a structure format; they are available when needed, held securely, tracked accurately and disposed of appropriately
How new staff will be made aware of the policy and manager action	Via Must Read on the Trust Intranet .
Specific Issues to be raised with staff	All staff who handle casenotes in the course of their duties should be aware of the Appendices 1 to 10
Training available to staff	Casenote Training delivered by the Health Records Department
Any other requirements	None
Issues following Equality Impact Assessment (if any)	None

Location of hard / electronic copy of the document etc.	The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

APPENDIX 12: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Health Records Policy
Division/Directorate and service area	IMT
Name, job title and contact details of person completing the assessment	[redacted], Head of Records Management
Date completed:	September 2019

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This policy is intended to ensure that the Trust's management of Health Records supports the Trust in its strategic objectives and the delivery of safe patient care. The Trust will ensure that Health Records are kept confidential, accessed only by those that need it; the information contained within them is accurate, up to date and in a structure format; they are available when needed, held securely, tracked accurately and disposed of appropriately

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☐ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men) ***Please insert an "x" in the appropriate box*** *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒

Disability	☐	☒
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

None

5. Do you think the document meets our human rights obligations? ☐

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

No concerns regarding equality were raised during the revision of this policy. The document has previously undergone a focussed consultation process to ensure that all those involved in the development and management of procedural documents have had the opportunity to comment. This version has only had minor amendments.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	*Not applicable*
Issue:	*Not applicable*
How is this going to be monitored/ addressed in the future:	*Not applicable*
Group that will be responsible for ensuring this carried out:	

Document Control

Title			
Healthcare Records Policy			
Author [redacted]		**Author's job title** Healthcare Records Manager	
Directorate Digital Healthcare Services		**Department** Healthcare Records	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
1.0	Sept 2006	Final	Published on Tarkanet
1.1	Nov 2007	Revision	Revisions made in line with requirements for NHS Litigation Authority assessment.
1.2	Feb 2008	Revision	Approved by Healthcare Documentation Group
1.3	May 2008	Revision	Presented to Clinical Services Executive Committee for final Approval. Ratified by Trust Board.
2.0	May 2008	Final	Published on Tarkanet.
2.1	May 2010	Revision	Revised to include requirements for NHS LA standards, process for retention, disposal and destruction of records extract from Records Lifecycle policy. Minor amendments by Corporate Affairs to document control report, header and footer, bookmarks and hyperlinks for appendices, and corrected the contents list numbering. Formatted for document map navigation. NHSLA text added.
2.2	Sept 2011	Revision	Harmonised policy as a result of the merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. The monitoring section has been strengthened as a result of revised NHSLA requirements.
2.3	Jan 2012	Revision	Amendments by Corporate Governance to update policy to latest template. A summary of key issues and differences is on page 3. Formatting for document navigation and table of contents, new NHSLA references, training section added. The training and monitoring sections have been strengthened as a result of revised NHSLA requirements.
3.0	Mar 2012	Final	Approved by Information Governance Steering Group on 22nd February following consultation subject to amendments. Amendments incorporated and published.
3.1	Oct 2012	Revision	Safeguarding children information added at the request of the Named Nurse Safeguarding Children (see section 12) and reference to child protection policy (see section 26).
3.2	May 2013	Revision	Child protection changed to Safeguarding children policy
4.0	Nov 2015	Final	Approved by the LCC Facilities on 29/12/15
4.1	Mar 2017	Final	Amended in line with the implementation of TrakCare and RIO
4.2	Aug 2018	Final	Amendment in line with the implementation of iFIT
4.3	Oct 2019	Revision	Amendment in line with directorate change
4.4	Dec 2019	Revision	Amendment to audit guidance and for review by RMG

4.5	Aug 2020	Final	Approved by RMG and IMSG
5.0	Dec 2021	Revision	Amendment in line with the update in the Records Management: NHS Code of Practice for Health and Social care 2021

Main Contact
Healthcare Records Manager
Northern Devon Healthcare Trust
North Devon District Hospital
Level 2, Raleigh Park
Barnstaple EX31 7BJ

Tel: Direct Dial – [redacted]
Tel: Internal – ex [redacted]
Email: [redacted]

Lead Director
Chief Information Officer

Superseded Documents
Healthcare Records Policy and Procedures
NHS Devon / Devon Provider Services Healthcare Records policy

Issue Date	Review Date	Review Cycle
August 2020	August 2023	Three Yearly

Consulted with the following stakeholders: (list all)

- Records Management Group
- Compliance Manager
- Additional transferred group staff /stakeholders
- EHR Functional/Operational/Change Management Leads

Approval and Review Process

- Information Governance Steering Group

Local Archive Reference
G:\Healthcare Records
Local Path
G:\HealthcareRecords\Policies and Procedures
Filename
Healthcare Records Policy v4.5 Aug 2020 - final

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
Clinical Governance, Healthcare Records	Medical notes

CONTENTS

1. Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for the development and management of healthcare records. Records are regarded as a vital resource because of the information they contain. This information is only an asset if it is recorded correctly, regularly updated and is easily accessible.

This policy provides a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties as set out in the NHS Constitution.

It applies to all clinical records in any format or media type, whether produced internally or acquired from an external source.

This is a merged policy reflecting the inclusion of Devon wide Specialist Services in 2015".

2. Purpose

The purpose of this document is to ensure the robust development and management of the healthcare records for all patients within the Trust, ensuring:

- Rational, evidence based intervention.
- Interventions recorded as effective and acceptable.

The following legislation and codes of practice are incorporated into the management of healthcare records:

- Access to Health Records Act 1990
- Audit Commission Report 1995
- Caldicott Review 1997
- Clinical Negligence Scheme for Trusts (CNST) established 1994
- Confidentiality: NHS Code of Practice 2003
- Controls Assurance (NHS Executive Standards) HSC 2001/005
- Environmental Information Regulations 2004
- Freedom of Information Act 2000
- General Data Protection Regulation (GDPR)
- Information for Health (HSC 1998/168)
- Public Records Act 1958, section 3 (1 – 2)
- Records Management: NHS Code of Practice for Health and Social Care 2021
- Removable Media Guidelines

This policy applies to all Trust staff. All staff (including temporary and agency) must comply with this policy as a condition of their employment. A breach involving unwarranted disclosure or destruction of Trust information may result in disciplinary action.

3. Definitions

3.1. What is a Healthcare Record

A Healthcare record is anything that contains clinical information which has been collated or created as part of the work of any NHS employee. At NDHT the paper record is considered the definitive source of a patient's full medical history, so it is essential that all relevant letters, results etc are accurately filed in a timely manner to prevent missing information and potential clinical risk.

This includes all patient clinical paper, documents uploaded or imported into the Trusts Electronic Health Record (EHR) systems TrakCare and RIO, microfiche, audio, computer data, any removable storage media (USB Pens, mobile phones, cameras, compact discs (CD) and digital video disc (DVD) and work diaries etc.

Removable Media Guidelines

4. Responsibilities

4.1. Role of Chief Executive and Senior Managers

The Chief Executive and Senior Managers are responsible for:

- Under the terms of the Public Records Act 1958 S.3 (1) - (2) it is acknowledged that the Chief Executive and Senior Managers are personally accountable for records management within the Trust and have a duty to arrange the safe keeping of those records.
- Ensuring that all records created or held by the Trust are managed to the highest NHS and legal standards.

4.2. Role of the Healthcare Records department staff

Healthcare Records department staff are responsible for:

- Compiling a new set of records for each newly registered patient.
- Storing all records in a location based filing system.
- Pulling files on request for clinics for Acute and Community.
- Electronically tracking all Healthcare records both in and out of the department.
- Archiving and destroying records as per the Records Management: NHS Code of Practice for Health and Social Care 2021
- Inclusion of 'Special' Notices such as, Living Wills.

4.3. Role of all other staff

All other staff are responsible for:

- All NHS employees are responsible for any records which they create or use. This was established and defined by the Public Records Act 1958. Furthermore, any records created by an NHS employee are public records.

- Ensuring that person and patient identifiable information is not passed on to others without the individual's consent.
- Everyone working for, or with the NHS, who records, handles, stores, or otherwise comes across patient information, has a personal common law duty of confidence to patients and to his or her employer.
- All members of staff have a statutory and contractual duty to accurately file documentation within any healthcare record that they generate.
- Filing of any loose signed miscellaneous filing before returning Healthcare Records, or visiting the Healthcare Records main file to securely file any loose documentation. Loose papers are NOT to be sent in the internal post.
- Requesting records in a timely way using the iFIT request system or telephone for urgent notes.
- Monthly case note tracking audits of their locations which must be submitted to the Healthcare Records manager.
- Entering details onto the iFIT system when moving records to a new location and when receiving notes
- The safety and confidentiality of notes whilst in their care.
- Community Staff using RIO must record all notes and assessments for a patient directly onto RIO. Some documentation will not be available in RIO. This includes patient owned/held documentation, supporting documentation, non-RIO services and third party documentation. Very specific Trust owned patient held documentation as outlined in the Standard Operating Procedure for Community Services EHR will continue to be held as a paper record in the patient's home (for example, Manual Handling Plan, Prescribed Medicines Administration Record). This specific documentation must be scanned and uploaded into RIO when completed/reviewed.

5. Healthcare Records Development and Management

5.1. Registration and identification

Once a patient has been registered on TrakCare and an appointment has been made a folder must be raised and prepared with the patients' name and track number in the form of a bar code label to be placed on the front cover, the notes must also be tagged.

Staff must ensure that the correct record is available for the patient being treated.

Within Health and Social Care a full set of relevant assessments will be started as clinically appropriate.

5.2. Folder style

- The style of healthcare records for the Trust is the standard yellow card folders. At present there are two styles used across the Trust, the other one being an older

style buff folder. Though they may differ in appearance, all healthcare records have identified sections with instructions for filing printed on the divider.

- Community Services will continue to use current folders where appropriate.

5.3. Format

- The patient's name and hospital number must be identified with a label on the front of each record.
- All entries in the record must be in permanent black ink (including theatre operation notes).
- All history sheets must have patient's name, NHS number and TrakCare number on them.
- An Outcome Form must be provided by Healthcare Records for every outpatient attendance which must be completed by the treating clinician at time of appointment.
- No entries are to be deleted using correction fluid. A line must be drawn through any incorrect entry and the amendment should be referenced with initials, printed name and dated by a clinician.
- Under no circumstances must a patient or relative write in a set of notes, only clinicians are allowed to do this.
- No loose documentation is to be kept within the file.
- All test results are to be mounted on the cards provided.
- Any Electro Cardio Graphs (ECG) traces are to be placed within an envelope marked with the patient's name and track number; this should then be secured in the results section.
- Any photographs that are taken should be securely filed within the patient's notes at the time of consultation.
- Any information that is held on any electronic system such as EPRO etc must be printed and then filed within that patient's main notes in a timely manner.

It is essential that all staff who handle notes file all documentation securely in the correct section. Further guidance can be found as follows:-

https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards

5.4. Filing standards

5.4.1. Folder cover

- The name and TrakCare number must be legible.
- The cover must be in good condition.

  If there is more than one volume, the volume number must be recorded clearly on the cover.

5.4.2 Inside the folder

- The plastic securing mechanism must be in good condition and in the secured position.

- All documents must be filed in the correct section, should be secured and in chronological order.
- All documents should be filed within the boundary of the folder.

5.4.3 Creation of additional volumes

Healthcare records folders are restricted to the volume of records they can safely contain. When documentation cannot be safely enclosed, a new volume must be requested from Healthcare Records. The start date for each new volume must be indicated on the front cover and when full the end date must be added.

5.5 Loose Filing

- Patient care can be jeopardised if information is missing from the healthcare record, has been filed incorrectly, or has not been filed at all. Results of tests or investigations that cannot be found or are missing could result in vital clinical care/work being delayed or the test being re-ordered.
- Whilst the person is an inpatient on a ward, it is the responsibility of the ward clerk to ensure that they maintain the patients' healthcare record file and that any documentation created during the inpatient episode is promptly and correctly filed.
- Whilst the person is a patient cared for by Community Services, it is the responsibility of the relevant healthcare professional to maintain the patients' healthcare record and to document each episode of care. The Community Health and Social Care Co-ordinators have responsibility to ensure any paper documentation created during the community episode is promptly and correctly scanned and uploaded in RIO.
- Any documentation created in outpatient clinics, should be filed by the secretarial / clerical staff before the record is returned to the Healthcare Records Department.
- All test results should be read, signed and dated by medical staff to indicate that they have been seen prior to being filed in the record. If no signature is evident it must be assumed that they have not been read or seen by a member of the medical team. Arrangements must be made to ensure this is done.
- No loose filing should be sent to the Healthcare Records Department for filing. All filing must be done simultaneously whenever possible and must be undertaken by the department holding those records at the time.
- For those patients where documentation has been created but the main notes are no longer with the individual that created said documentation, it is that member of staff's responsibility to locate the record and file the loose documentation. Staff should contact the Healthcare Records manager to arrange a suitable time to go to the HealthCare Records department to file the papers themselves, in line with Trust standards outlined above.

Whilst the person is a patient cared for by Community Services, it is the responsibility of the relevant healthcare professional to maintain the subject's healthcare record and to document each episode of care. The Community Health and Social Care Co-ordinators have responsibility to ensure any paper documentation created during the community episode is promptly and correctly scanned and uploaded in RIO Rio for Community Nursing Staff and AHPs.

Training can be obtained by contacting ndht.healthcarerecords@nhs.net

6. Transporting records

Any transportation or movement of records within or outside the Trust must be tracked so their location is known at all times (see Section 7).

6.1. Within the Trust

When transporting records between departments they should be delivered or collected by an authorised member of staff. The record should be transported in a clearly addressed sealed envelope or box/bag.

When transporting records between separate Trust sites this should be done using the official internal postal system. Records should be transported in a secure box/bag.

When delivering records for clinics these should be transported using covered trolleys. The trolley should never be left unattended. Once delivered to the clinic area the records should be kept in a secure environment until they are required.

When transferring a patient from one ward to another, including North Devon District Hospital inpatient ward to a community hospital inpatient ward or vice versa, it is the responsibility of the discharging ward to correctly amalgamate the 'current' admissions notes within the main case notes.

Notes are picked up by the HealthCare Records Courier from all departments and clinical areas daily.

6.2. Outside the Trust

Sharing information to support care is essential for our patients who are being treated in Royal Devon and Exeter hospital, Derriford hospital and Musgrove Park hospital so we would send the original to these locations.

If requests are received from other hospitals to provide records, Healthcare Records should be contacted to arrange for a copy to be provided as an alternative.

Should staff be required to take a set of notes with them for a meeting off-site i.e. domiciliary visit at the home of a service user, the record should be carried in a suitable non-transparent bag or case, which must not be left unattended. If this is not possible the record must be carried in a sealed envelope.

Any records, notes or images sent outside the Trust can be sent by recorded delivery or electronically to a named NHS email account with consent.

Community Services must treat any information taken from a third party system, eg System One or Care First 6 in accordance with Information Governance Policy.

7. Tracking, requesting and retrieval

The exact location of each set of case notes must be known at all times, so they must be tracked using the RFID system (iFit).

7.1. Tracking records

The Trust uses the iFIT system to track its case notes across the organization by means of an RFID system which provides general detail as to the location of the file, but not specific detail. It is the responsibility of all staff to keep this tracer system up to date in recording the movement of all case notes.

All clerical staff are responsible for updating the iFIT system themselves at all times.

It is essential that iFit is updated with the precise location of the file whenever the file is moved to a different location – the file should be noted on iFit as being "Received" with the location.

Non clerical staff are responsible for either updating the iFIT system themselves if they have iFIT access or for informing a clerical member of staff which notes are being moved and to which location.

Regular monitoring of the use of the tracer system will be undertaken by the Healthcare Records Manager and any staff/areas found not be adhering to this policy will be brought to the attention of their line managers to ensure all staff take responsibility for tracing case notes at all times.

If any members of staff are found to be recurrently not adhering to the policy on using the tracer system then the Trust disciplinary process will be initiated.

A quick guide on how to electronically track notes can be found in Appendix A or training can be provided by contacting ITTraining@nhs.net.

7.2. Retrieving records

The retrieval of records is a task carried out by Healthcare Records Staff. Any records required for a patient either admitted to the hospital or attending a clinic is to be requested by telephoning the Healthcare Records Department, e-mailing the department at ndht.healthcarerecords@nhs.net or via the iFIT tracer system. No other staff are permitted to remove Healthcare records from the secure areas.

Regular clinic lists are printed off from the iFIT system and notes are pulled by the Healthcare Records staff and sent to the relevant location in readiness for the clinic. They must be returned afterwards by the Consultant's secretary, Department or the Clinician running the clinic.

7.3 Requesting records

Any requests for clinical audits must be managed through the Clinical Audit team who will raise an audit number and send a list of notes to Healthcare Records to pull and make available for the clinician to review within an agreed timeframe. For any additional audit requests, please use the form at Appendix D.

For any other notes requests, the "request" option should be used on iFit – this is for a maximum of **5** sets of notes per day per requester.

8. Scanning

To ensure the authenticity, integrity and availability of electronically stored health records, the detailed process in Appendix B must be followed.

- Any patient documentation should be scanned into an electric information system for example, Civica Cito and RIO.
- Any physical documentation that would be deemed necessary and/or note worth to a patient's health or wellbeing will need to be scanned
- Some documents may need to be retained when, due to poor quality of the original paper document, the scanned image is not of sufficiently-high quality. Where documents are to be retained in a hard copy health record, the Trust's standard case note folders should continue to be used. These are recognisable as Trust health records and maintain consistency across the Trust for the storage of hardcopy health records, filed in accordance with the Trust's Healthcare Records policy.
- Both electronic and hard copy records will be retained only for as long as necessary and in line with retention and destruction schedule in the NHS Records Management Code of Practice for Health and Social Care 2021 (https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016).
- Any physical documentation must be scanned before the patient is discharged from their current location in order for a full documented health record to be available at the point of care for the patient.

- For Community notes, hard copy documents can be scanned and attached to RIO, following the process outlined in the Standard Operating Procedure for Community EHR. This must be clinically relevant information that is not available elsewhere, for example hard copy referral, GP summaries.

9. Confidentiality

Healthcare records by their very nature are confidential. All staff are required to adhere to privacy and confidentiality regulations relating to both patient and staff information. The Trust will ensure that all precautions are taken to preserve confidentiality of all records that contain personal identifiable data and that no information is disclosed to unauthorised persons.

10. Security

Maintaining security and confidentiality of information is vital to the integrity of healthcare records and to protect patient and staff confidentiality. The following principles must be adhered to:

- All staff must ensure that they lock or log out from their computers whenever they leave their workstation.
- Records must be stored in secure areas to prevent unauthorised access by service users, members of the public or any unauthorised by staff, service users or members of the public.
- Records kept in areas that do not have 24 hour staff presence must be stored in an area that can be securely locked when the premises are unstaffed.

- At the end of the working day all staff must ensure that any records in their possession are kept in a secure location.
- The removal of original health records from any Trust site is not allowed, unless there are exceptional circumstances. Each request will be assessed on an individual basis by the line manager and/or the Information Security Manager.
- All breaches of confidentiality and missing files must be reported via the Trust's Incident Reporting Policy.
- Access to RIO will be restricted to those employed by NDHT including identified Social Care roles within the Health and Social Care Teams.
- Any other sharing of information will continue in accordance with the requirements of the Data Protection Act.

11. Living Wills

Living Wills are legally binding. If patients request to record their wishes for future care and treatment, this must be done in accordance with the 'Advance Statements about Medical Treatment - Code of Practice' report of the British Medical Association, April 1995 (see below):

- The Government is satisfied that the guidance contained in case law, together with the Code of Practice 'Advance Statements About Medical Treatment' published by the British Medical Association, provides sufficient clarity and flexibility to enable the validity and applicability of advance statements to be decided on a case by case basis.
- The patient is responsible for writing the Living Will. A copy must be sent to the Healthcare Records Manager, Northern Devon Healthcare Trust who will file it in the record and mark the notes accordingly. TrakCare will be updated accordingly.
- It is the responsibility of the patient or their representative to make staff aware of the existence of a Living Will and/or any amendments to the status of that 'Living Will'.
- People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of mental capacity. Just as adults must be consulted about treatment options, young people under the age of majority (age 18) are entitled to have their views taken into account.
- An advance statement (sometimes known as a living will) can be of various types.
- A requesting statement reflecting an individual's aspirations and preferences. This can help health professionals identify how the person would like to be treated without binding them to that course of action, if it conflicts with professional judgement.
- A statement of the general beliefs and aspects of life which an individual values. This provides a summary of individual responses to a list of questions about a person's past and present wishes and future desires. It makes no specific request or refusal but attempts to give a biographical portrait of the individual as an aid to deciding what he or she would want.
- A statement, which names another person who should be consulted at the time a decision, has to be made. The views expressed by that named person should reflect what the patient would want. This can supplement and clarify the intended scope of a written statement but the named person's views are presently not legally binding in England and Wales. In Scotland, the powers of a tutor dative may cover such eventualities.

- A clear instruction refusing some or all-medical procedures (advance directive). Made by a competent adult, this does, in certain circumstances, have legal force.
- A statement which, rather than refusing any particular treatment, specifies a degree of irreversible deterioration (such as a diagnosis of persistent vegetative state) after which no life sustaining treatment should be given. For adults, this again can have legal force.
- A combination of the above, including requests, refusals and the nomination of a representative. Those sections expressing clear refusal may have legal force in the case of adult patients.
- A copy of the Contingency Plans is electronically stored in the Rapid Intervention Centre. A hard copy is stored in the patient hand held notes until such time as a patient is discharged or dies when they will be stored in accordance with the Trust's Healthcare Records Policy.

12. Safeguarding Children Information

- A safeguarding children divider should be included in the healthcare record when there are/have been safeguarding concerns related to an unborn baby, child or young person.
- The safeguarding children section should be the first section in the healthcare record.
- Information should be filed in chronological order.

12.1. Unborn babies

- If there are safeguarding concerns related to an unborn baby, a safeguarding children section should be created within the mother's healthcare record.
- Once the baby is born, all safeguarding children information filed in the mother's healthcare record must be photocopied and filed within the safeguarding section of the baby's healthcare record.

Please see the Trust's Safeguarding Children Policy.

13. Alerts

Northern Devon Healthcare Trust recognise that the use of electronic alerts functionality within TrakCare and RIO can improve patient care by highlighting vitally important clinical or safety factors that may need to be taken into account for individual patients. The alerts function also highlight important information about a patient to appropriate members of staff. The system is operated in the interests of both patient and staff safety.

TrakCare and RIO allow electronic alerts to be added to patients' records, and these alerts then appear at many transaction points within the system. Some of the alerts have specific icon associated with them whilst others have a generic patient alert icon.

13.1 Alert Types

There are the specific alerts that are available on TrakCare and RIO from a drop down pick list. Appendix C of this policy contains a full list of alerts available for use.

13.2 Restricted Alerts

Restricted alerts can only be added, edited or removed by a specific alert administrator working within an area of specialist expertise, both clinical (eg methicillin-resistant staphylococcus aureus [MRSA]) or covered by specific policies (eg Aggression, Violence and Harassment).

14. Research

A notification of patient participation in a research trial should be evident in the form of a sticker on the inside of the front cover of each medical record folder. A copy of the information sheet and signed consent form should be placed in the notes.

The retention schedule for research notes must be adhered to.

15. Auditing

Audit plays a vital part in ensuring the quality of care that is delivered. Auditing can assess the standard of the record and identify areas requiring improvement and staff training. Audit tools have been developed to monitor the standards of records and also form a basis for discussion and measurement. The audit covers:

- Access
- Availability
- Security
- Storage environment
- Retention
- Disposal

As with all record keeping procedures it is important to observe confidentiality when dealing with client information. An informal audit of the above standards should be completed quarterly by the Healthcare Records Manager. This audit should consist of Case notes from different specialties and where possible from different sections within the healthcare records storage areas to assess compliance with the Healthcare Records Policy and Guidelines.

Any requests for audits that do not fall within the remit of the Clinical Audit team's framework should be made using the form at Appendix D (which can also be found on Bob) to ensure appropriate notice is given so that day to day duties are not impacted.

16. Retention and destruction of records

- The retention period depends upon the type of record and its importance to the business of the Trust. Destruction of records is an irreversible act, whilst the cost of keeping them can be high and continuing.
  - The Records Management: NHS Code of Practice for Health and Social Care 2021

- https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016) takes account of legal requirements and sets out the **minimum** retention periods for both clinical and administrative records. Trusts have local discretion to keep material for longer, subject to local needs, affordability and historical value.
- If a particular record is not listed within the schedules (on the Trust's intranet site and clipboards in storage areas) advice must be sought from the Information Governance Manager who will establish the appropriate retention period in consultation with other Records Managers, the Digital Healthcare Services and the service concerned.
- Where the record in question is a Trust-wide document, the retention period will need to be approved by the Governance Committee. Retention periods will be considered during policy review.
- The processes and schedule for the retention and destruction of healthcare records can be found in the Retention & Destruction of Healthcare Records Procedure.

16.1. Disposing and destroying unwanted records

- Many NHS records contain sensitive or confidential information. It is vital to safeguard confidentiality at every stage and to apply a fully effective destruction method when required (see the Confidentiality Policy and Waste Management Procedure). Normally, this involves shredding, pulping, or incineration.
- If there is doubt about the case for disposal of particular records, advice may first be sought from the Information Governance Manager or the Caldicott Guardian.
- CD/backup tapes/audio tapes must be reformatted with a random pattern to ensure data cannot be recovered or they must be physically destroyed following the Information Security Policy.
- Likewise, removable media and HDUs must be destroyed, in line with the Information Security Policy This can be done on site, or via an approved contractor.
- A brief description should be kept of everything destroyed (particularly if done so in error / accidentally). The Trust needs to know if and why information is no longer available when responding to information requests.

17. Training requirements

All staff should be made aware of their record keeping responsibilities, whether clinical or non-clinical staff.

All administration staff that handle case notes are required to undertake Healthcare Records training and should contact the Healthcare Records Manager to arrange for this within 6 weeks of commencing employment at the Trust.

Signed records must be kept of all training undertaken in the Trust. These records will be held by the Healthcare Records Manager. Individuals are encouraged to keep a copy of this in their portfolio.

The training matrix will detail:

- All administration staff must be trained on Induction with refresher training given on request.
- Training is given – face to face.

18. Monitoring Compliance with and the Effectiveness of the Policy

18.1. Standards/ Key Performance Indicators

Key performance indicators comprise:

- Information Governance Toolkit
- Complaints
- Incidents
- Internal Audits

18.2. Process for Monitoring Compliance and Effectiveness

Monitoring Arrangements

Compliance of this policy against all minimum requirements in the NHSLA Risk Management Standards will be monitored on a continuous basis with a continuous rolling audit and assessment of healthcare record related complaints and incidents or of misplaced records or not completed clinic lists.

Responsibility

The Healthcare Records Manager will be responsible for monitoring and reporting to Records Management Group

Reporting Arrangements

The result of the audits will be reviewed by the Records Management Group

Audit results

The Records Management Group will develop an action plan to improve compliance and ensure improvements in performance occur.

Action plans will be implemented by the Healthcare Records Manager in conjunction with any Head of Department or Divisional General Manager to ensure learning takes place.

The Records Management Group will monitor progress of the action plan on a monthly basis and exceptions will be reported via this group to the Quality Assurance Committee. Identified risks related to the non-compliance with this policy through audit will be registered on the Trust Risk Register system by the Risk Co-ordinator.

Where non-compliance is identified, support and advice will be provided to improve practice.

19. References

- Professional codes of practice and guideline eg Nursing and Midwifery Council (NMC)
- Code of Practice ‘Advance Statements about Medical Treatment’, British Medical Association 1995

- Access to Health Records Act 1990
- General Data Protection Regulation (GDPR)
- Freedom of Information Act 2000
- Access to Medical Reports Act 1988
- The Department of Health website provides further information on health records management: www.dh.gov.uk
- An Organisation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS. (2000)
- Confidentiality: NHS Code of Practice. (2003)
- NHS Information Governance: Guidance on Legal and Professional Obligations. (2007)
- Information Security Management: NHS Code of practice. (2007)
- NHS Information Governance: Guidance on Legal and Professional Obligations. (2007)
- The NHS Records Management Code of Practice for Health and Social Care. (2021)
- A Question of Balance: Independent Assurance of Information Governance Returns. Summary of Guidance. (2010)
- The NHS Constitution: The NHS belongs to us all. (2010)
- Care Quality Commission (CQC). (2009). the right information, in the right place, at the_right time: A study of how healthcare organisations manage personal data. London: CQC. Available at: www.cqc.org.uk
- Nursing and Midwifery Council. (2009). Record Keeping: Guidance for Nurses and Midwives. London: Nursing and Midwifery Council. Available at: www.nmc-uk.org

20. Associated Documentation

- Access to Patient Records Procedure
- Community Services Standard Operating Procedure for an Electronic Health Record
- Confidentiality Policy
- Disciplinary Policy
- Information Lifecycle Management Strategy
- Information Security Policy
- Managing Violence & Aggression Policy
- Removable Media Guideline
- Resuscitation Policy
- Retention & Destruction of Healthcare Records Procedure
- Risk Management Policy
- Risk Management Training Policy
- Safeguarding Children Policy

- Waste Management Procedure

21. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			X	
Disability			X	
Gender			X	
Gender Reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			X	
Pregnancy			X	
Maternity and Breastfeeding			X	
Race (ethnic origin)			X	
Religion (or belief)			x	
Sexual Orientation			x	

APPENDIX A: A Quick Guide on how to electronically track a set of notes

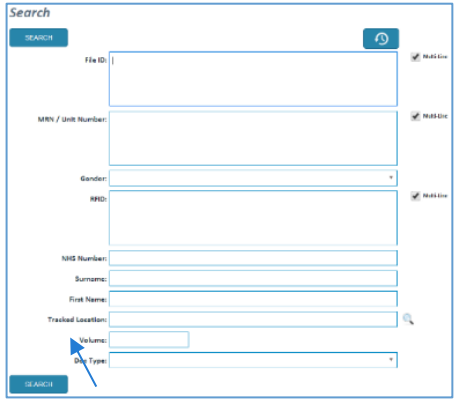
Search

Fields appearing on the **Search** screen can be customised by the Administrators of the system. In ***iFit***, the following fields are typically made available to the user for searching:

- MRN Number
- Barcode
- RFID
- Volume No
- Patient Name & Surname
- Document Type
- Patient NHS Number

To Search

1. Click in the respective field and enter the required search criteria. Entering search criteria can be performed either via
   - manual entry or selection (if a drop down field) or
   - handheld barcode reader



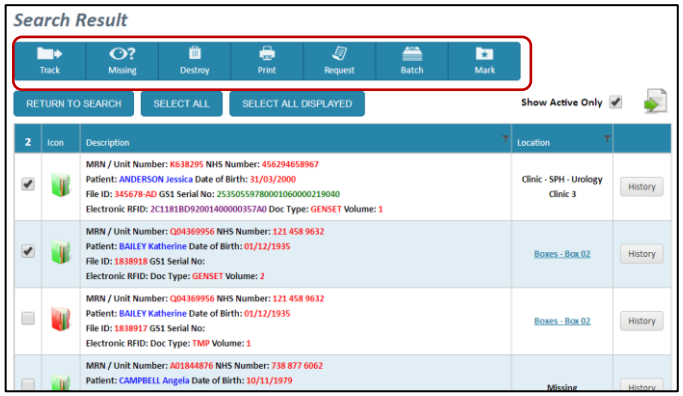
2. Once entered, click the '**Search**' Button.

TIP Instead of clicking the search button the following shortcuts are available:
- In a **Single entry field** - Press the '**Enter**' Key
- In a **Multi-Line entry** - Press the '**alt+Enter**' Keys

Working with Search Results

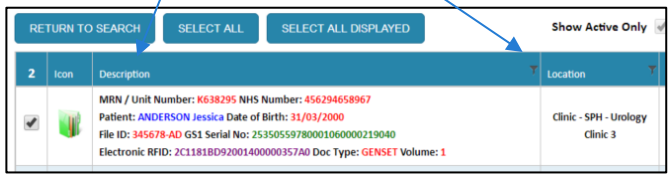
Once the **Search Results** are displayed, depending on access permissions, users have the following actions available:

- **track** selected files / containers to another **Location**
- mark selected files as **Missing** or **Cannot Find**
- **destroy** selected files
- print **Barcode Labels** for selected files on the user's default printer
- create a **request** for the selected **files**



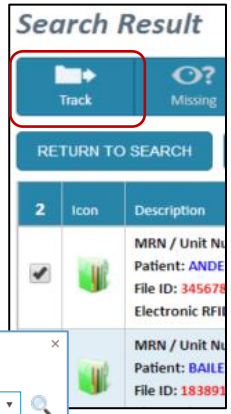
Search Results may be:

- filtered using filter icon
- sorted by clicking the title



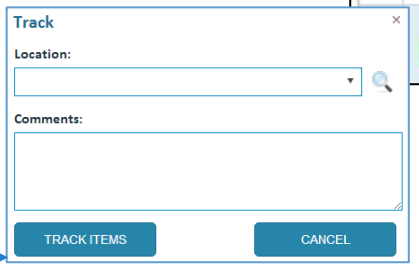
Tracking to a New Location

Selected files from the **Search Results** can be **Tracked** to a new **Location** by clicking the '**Track**' Button



To **Track files**:

1. Select the required files from the **Search Results**
2. Click the **Track** Button
   iFit will open up the **Tracking** popup window.

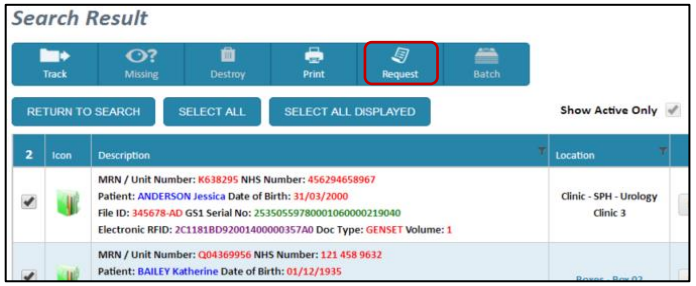


3. Select required **Location** from:
   - the **Location** dropdown field
   - via the '**Lens**' Icon (if available)
   - Typing in the **Location** Code (if known)
   - Scanning in the **Location** barcode (if available)
4. Enter any appropriate comment (if deemed necessary)
5. Click the '**Track Items**' Button.

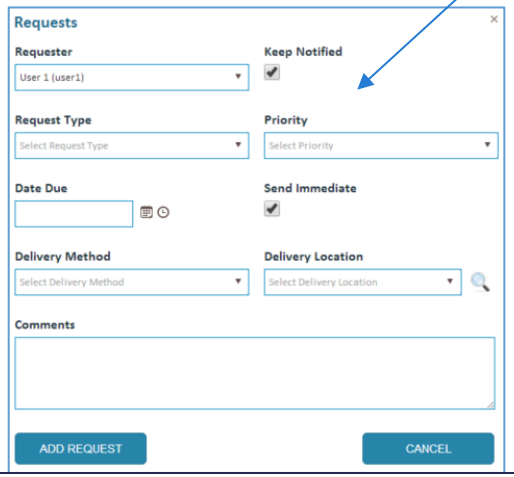
Requesting Files

To **Request** Files:

1. **Search** for **files**
2. From the **Search Results**, select the **files** that need to be **requested**
3. Click the **Requests** Icon.



A popup window is displayed to enter the **Request** requirements

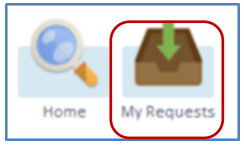


4. Select the
   - Request Type,
   - Priority of Request,
   - Delivery Method,
   - Delivery Location.

   iFit may display differently to the screen shown due to your specific configuration.
   iFit may have been configured to send requests immediately or enter into a **Pending** status before sending.
5. Should ***iFit*** display the '**Send Immediate**' tick box, then tick if the request for files is to be sent automatically or untick (empty) if the request for files is to be sent at a later stage.
   Should ***iFit*** not display the '**Send Immediate'** option, then this means that **request for files** will automatically be processed upon completion of Step 6 below.
6. Click the '**Add Request**' Button

Sending File Requests

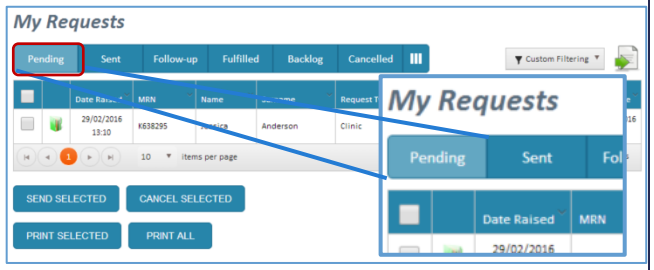
When a request for files is created, and '**Send Immediate**' is not ticked, the **requests** are still in a state of transition.



To actually submit the **requests**, click the '**My Requests**' button at the top of the screen.

To **process** any **requests** in such a 'transition state':

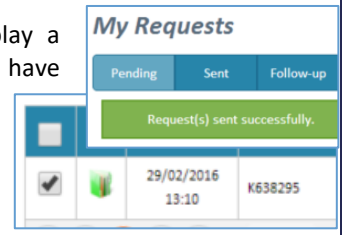
1. Navigate to the '**Pending'** tab after clicking the '**My Requests**' icon.



2. Select the required **Requests** by ticking next to each of the requests

3. Click the '**Send Selected**' button

Once processed, ***iFit*** will display a notification that the **requests** have been sent successfully.



The selected **requests** can now be found in the '**Sent**' tab.

APPENDIX B: Scanning of Documents

All paper documents need to be examined prior to the scanning process, to ensure that as high a quality image as possible is obtained.

1. Remove all staples, clips or other document bindings ensuring that there is no damage to the original that may affect the capture of information from the document

2. Remove any poly pockets/plastic wallets

3. Ensure that all physical attachments eg post it notes, medical results attached to mount sheets, are removed and photocopied separately before scanning

4. Anything stuck onto a page such as labels must be firmly attached, especially at the edges. They should not be obscuring anything underneath

5. Where the paper is very old and thin and unlikely to pass through the scanner this should be photocopied initially and then scanned.

6. If the quality of the print is poor this should be photocopied with a higher resolution using the photocopier.

7. Where originals are photocopied please check the quality of the photocopy

8. Ensure that all the information contained on the original is retained on the photocopy

9. Anything that has been successfully photocopied ensure that nothing is duplicated in the scanning process.

10. Handwriting (or hand drawing) using pencils can be faint, and difficult to reproduce. Care should be taken when scanning to ensure that image brightness and contrast are appropriate for these images.

11. Check the physical state of the paper. The top edges of each sheet have to be 'grabbed' by the scanning rollers, so they should be straightened out if folded if using a scanner with rollers

12. Ensure all pages of a multi- page document are kept together and in the appropriate order before, during and after scanning

13. Ensure every page and the entire page is scanned

14. Check that all the information in the document pertains to the same patient (NHS number, name and date of birth). If misfiled information is found it must be removed and relocated in the appropriate record.

15. Mark/stamp the scanned document “Scanned” once the above steps have been completed and the quality of the scanned document has been checked, if the scanned document is being kept for a period of time.

16. The scanned documents will be saved against the correct patient record.

17. Scanned documents should not be printed unless absolutely necessary.

18. If scanned documents are to be printed, all hard copies should be checked against the current electronic version prior to use.

19. Records can be printed if required to satisfy a subject access request under Section 7 Data protection or a Freedom of Information request.

Documents to be scanned

- Referral letters
- Clinical information
- Test results

Appendix C: Patient Alerts

Alert Category	Associated Alert	Icon Associated	Added/Amended by Team	Restricted by Access Profile	Viewed by	Notes
Adult at Risk	Adult at Risk	Y	Health and Safety Manager	Y	All	
	At risk of domestic violence	Y	Health and Safety Manager	Y	All	
Breastfeeding	Breastfeeding	Y	All	N	All	
Clinical	Cancer Patient	N	All	N	All	
	Diabetic Patient	N	All	N	All	
	Difficult intubation/airway management	N	All	N	All	
	Life threatening intra-operative event in past	N	All	N	All	
	Muscular Dystrophy	N	All	N	All	
	Myotonic Dystrophy	N	All	N	All	
	Porphyria	N	All	N	All	
	Ready Steady Go - transition to Adult Healthcare	N	All	N	All	
	Suxamethonium (Scoline) apnoea	N	All	N	All	
	Trial Patient contact 3867	N	All	N	All	There is a current process in place
Enhanced Observation	Enhanced Observation	Y	All	N	All	
General	Lasting Power of Attorney	Y	Healthcare Records Manager	N	All	There is a current process in place
	No blood products	N	All	N	All	
	Patient known to Community Health and Social Care Team	N	All	N	All	There is a current process in place
	Patient on frailty pathway	N	All	N	All	There is a current process in place

High Risk	Anaesthetic high risk	N	All	N	All	
	Patient Receiving chemotherapy Bleep 500	N	All	N	All	
	Clozapine - Urgent Contact Psychiatry	N	All	N	All	
Infection Control	Carbapenum Resistant Organism	Y	Infection Control	Y	All	
	Clostridium Difficile	Y	Infection Control	Y	All	
	Extended Spectrum Beta-Lactamase	Y	Infection Control	Y	All	
	Infectious diarrhoea	Y	Infection Control	Y	All	
	Infectious Other	Y	Infection Control	Y	All	
	Infectious respiratory illness	Y	Infection Control	Y	All	
	Influenza A	Y	Infection Control	Y	All	
	Influenza B	Y	Infection Control	Y	All	
	MRSA	Y	Infection Control	Y	All	
	Norovirus	Y	Infection Control	Y	All	
	Patient at risk of CJD	Y	Infection Control	Y	All	
	Respiratory Syncytial Virus	Y	Infection Control	Y	All	
	Rotavirus	Y	Infection Control	Y	All	
	Tuberculosis	Y	Infection Control	Y	All	
	VRE Positive	Y	Infection Control	Y	All	
Learning Disability	Learning Disability	N	Learning Disability	Y	All	
Living Will	Living Will	Y	Healthcare Records Manager	N	All	There is a current process in place
Major Trauma	Major Trauma	Y	All	N	All	
Mental Health	Under Mental Health Act	N	All	N	All	
Podiatry Patient	Various alerts	Y	Podiatry	Y	All	These will only be used by the Podiatry team

Safeguarding Children	Current Child Protection Plan	Y	Children's Safeguarding	Y	All	There is a current process in place
	Looked after child	Y	Children's Safeguarding	Y	All	There is a current process in place
	Previous child Protection Plan	Y	Children's Safeguarding	Y	All	There is a current process in place
	Previous Looked after child	Y	Children's Safeguarding	Y	All	There is a current process in place
Security Risk	Staff Safety	Y	Safety Officer	Y	All	Process agreed
Special Admin Needs	Hard of hearing	Y	All	N	All	
	Learning Disability (Special Admin Needs)	Y	All	N	All	This alert is added when there is a an LDIS alert already in place and only if there is special needs required for OP appointments
	Patient opted out of correspondence	Y	All	N	All	
	Registered blind correspond by tape	Y	All	N	All	
	Registered blind	Y	All	N	All	
Specialist Bed	Duo 2 Bed	Y	All	N	All	
	Hi Low Bed	Y	All	N	All	
	Plus size with air mattress	Y	All	N	All	
	Plus size with static mattress	Y	All	N	All	
Spinal Cord Injury	Spinal cord injury	Y	All	N	All	
Suspected Infection Control	Diarrhoea	Y	Infection Control	Y	All	
	Flu-like Illness	Y	Infection Control	Y	All	
	Vomiting	Y	Infection Control	Y	All	
Transitional Care Baby	Transitional Care Baby	Y	All	N	All	

Appendix D: Healthcare Records Notes Request Form (for Audits)

Priority:
URGENT (Requests relating to immediate patient safety issues) – **24 hours** MEDIUM (Requests relating to benchmarking, Clinical Audit etc.) – **1 week** LOW (Other ad hoc enquires not covered above) – **2 weeks**
If you need the files by a specific date please state when/why etc: (eg *information is required for a meeting or a report). Please do not state ASAP as this request will be returned for more clarification:*
Details of Request:
Please specify any other information that you think will help us to complete your request as soon as possible:
Requested by: **Department:** **Date:**

Extension granted to September 2021 by IGSG on 16 March 2021

Records Management Policy

Post holder responsible for Procedural Document	Patient Records Manager
Author of Policy	Patient Records Manager
Division/ Department responsible for Procedural Document	Information Management & Technology (IM&T)
Contact details	[redacted]
Date of original document	January 2008
Impact Assessment performed	**Yes**/No
Ratifying body and date ratified	Information Governance Steering Group (IGSG): 16/01/2017
Review date (and frequency of further reviews)	15/01/2020 (every 3 years)
Expiry date	December 2020-extention to Sep-21
Date document becomes live	31/01/2017

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information	**Strategic Directions – Key Milestones**
Patient Experience	Maintain Operational Service Delivery
Assurance Framework	Integrated Community Pathways
Monitor/Finance/Performance	Develop Acute services
CQC Fundamental Standards - Regulation**:**	Infection Control
Other *(please specify)*:	
Note: This document has been assessed for any equality, diversity or human rights implications	

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1.0	January 2008	Health Records and Information Governance Manager	New policy
2.0	7th June 2013	Information Governance Manager	Revision of existing policy.
3.0	December 2013	Information Governance Manager	Revised to incorporate BS10008 and eNotes
4.0	December 2016	Patient Records Manager	Draft Revision of existing policy
5.0	January 2017	Patient Records Manager	Revision of existing policy

Associated Trust Policies/ Procedural documents:	Business Continuity Management Policy Computer and IT Usage Policy Consent to Examination or Treatment Policy Data Quality Policy Data Storage Policy Email Policy Freedom of Information Act 2000 and Environmental Information Regulations Policy Health Records Policy Incident reporting, analysing, investigating and learning policy and procedures Information Governance Policy Information Security Policy Internet Use Policy Mobile Phone Policy Photography and Video-recording of Patients Policy and Procedure Security Policy Software Policy
Key Words	Records Management
In consultation with: Lead Nurses, Information Asset Owners, (IAOs) Community Divisional Manager/Lead Nurse, Governance Leads, (all 6 Dec 2016), Policy Expert Panel (PEP) 03/01/2017, Records Management Group 11/01/2017, Information Governance Steering group (IGSG) including Senior Information Risk Owner (SIRO) (16/01/2017) ; Policy Expert Panel Chair (Jan 2017)	
Contact for Review:	Patient Records Manager

Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	[redacted] **Medical Director**

CONTENTS

1. INTRODUCTION

1.1 The Records Management Policy for the Royal Devon and Exeter NHS Foundation Trust (hereafter known as the Trust) is for the management of records of patients, staff, complaints, corporate records and any other records held in any format including both paper and digital. This document sets out the Trust's policy on the management of records through their lifecycle ie from creation to eventual archiving or destruction.

1.2 **Failure to comply with this policy could result in disciplinary action.**

.

2. PURPOSE

2.1 This document sets out an overarching framework for integrating current records management initiatives, as well as recommending new ones. It defines a strategy for improving the quality, availability and effective use of records in the Trust and provides a strategic framework for all records management activities

2.2 This policy is intended to ensure that the Trust's records management practices support the Trust in its strategic objectives and the delivery of patient care. The Trust

will ensure that the management of records meets legal and professional obligations under Section 46 of the FOIA, Section 51 (4) of the DPA, Caldicott principles , the NHS and Social Care, `Care Record Guarantees` and professional standards for record keeping such as The Academy of Medical Royal College (AoMRC) generic medical record keeping standards.

2.3 The Trust is committed to a systematic and planned approach to the management of records that ensures from the time a record is created until its ultimate disposal, the control of both the quality and quantity of information, the maintenance of information is performed in a manner that effectively services the needs of the Trust and its stakeholders and compliance with appropriate legislation.

2.2 All NHS records are public records under the terms of the Public Records Act 1958. NHS employees are responsible for records they create. Records, once created are public records for which members of staff have a personal common law duty of confidence. The Secretary of State for Health and all NHS organisations have a duty under the Public Records Act 1958 to make arrangements for the safe keeping and eventual disposal of all types of their records.

2.3 The NHS Records Management: Code of Practice for Health & Social Care 2016, published by the Information Governance Alliance for the Department of Health, is a guide to the required standards in records management for those who work for the NHS in England. It incorporates current legal requirements and best practice.

2.4 This policy provides the high-level guidance for all clinical and non- clinical operational records held in any format by the Trust eg:

- Paper records, reports, diaries and registers etc
- Electronic records
- X-rays and other images
- Microform (ie microfiche and microfilm) and
- Audit and video tapes

These records include:

- All administrative records (e.g. personnel, estates, financial and accounting records, notes associated with complaints); and

- All patient health records (this includes all specialties and including private patients, including x-ray and imaging reports, registers, databases etc.) The operational management of patient health records is dealt with in the Health Records Policy.

2.5 Every member of staff has some element of Information Governance responsibility. The policy sets out responsibilities for staff and managers to ensure that they comply with the l egal and policy obligations on the Trust. It also imposes requirements for monitoring and audit so the necessary assurances can be supplied.

2.6 The aims of the Records Management Policy are to ensure:

- A systematic and planned approach to records management ensuring standardisation across the Trust covering records creation, storage and disposal in line with National Standards and legislation

- Efficient and best value through improvements in the quality and flow of information and greater co-ordination of records and storage systems to ensure where possible best practice is shared and duplication avoided

- An active destruction, retention and archiving policy for all administrative records to ensure records are destroyed when they are no longer required

- Training and awareness of the records management programme with appropriate staff groups to ensure they are aware of their responsibilities

3. DEFINITIONS

3.1 **Records Management**
Records Management describes the system of controlling creation, version control, distribution, filing, retention, storage and disposal of records throughout their life cycle.

3.2 **Record Life Cycle**
The Record Life Cycle describes the life of a record from creation/receipt through the period of 'active' use into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either disposal or preservation.

3.3 **Records**
Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business. A record is a document which has been declared as a formal record, constituted of both content and metadata.

3.4 **Document**
Documents provide guidance and/or direction, or render judgments which affect the quality of the products or services delivered; documents can be altered, revised, and require less stringent control than records. Documents precede records in the information life cycle; records are formed by declaration of documents.

3.5 **Declaration**
The process of defining that a document's contents (and some of its metadata attributes) are frozen as it formally passes into corporate control and is thereby declared as a record, indicated that a document is of corporate value.

3.6 **Metadata**
Data describing the management, context, content and structure of records.

3.7 **Information**
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.

3.8 **Archives**
Are non-current or closed records. These records may be in any format (eg electronic or paper) and must be subject to robust controls to ensure that they remain accessible should they be required at a future date.

3.9 **Information Asset**
An information asset is a system that holds data, both demographic and activity, examples include (but are not restricted to):

- Patient Administration System (PAS)
- Physical Health Record

- Medway
- Stork Maternity
- Clinical Document Management System (CDM)
- Electronic Staff Record (ESR)

3.10 **Convenience Copy**
A copy taken of a record that is to be used for a limited period and then destroyed. The master copy is retained.

3.11 **Permanent Records**
Records that have archival value and will be retained for historical purposes after their retention period has expired.

3.12 **Health Record**
This is defined as anything that contains information in any media that has been created or gathered, as a result of any aspect of the work, of healthcare employees which supports patient care and includes agency/casual staff. The health record is the Trust's main acute record and is also referred to as medical record, hospital record, patient case notes, patient record or patient notes. Information held in the following systems (but not restricted to) will also be considered to be a part of the patient record:

- PAS
- CDM
- WebPACS
- Stork Maternity
- Medway

3.13 **BS10008**
This is the British Standard for the evidential weight and legal admissibility of electronic information. Where electronic information is managed in conformity with this standard, the evidential weight of that information is maximised by ensuring its trustworthiness and reliability. Conformity with this standard minimises the risks associated with the long-term storage of electronic information.

To do this, BS10008 specifies requirements for the implementation and operation of electronic information management systems, including the storage and transfer of information, and issues of authenticity and integrity of the information. This is important where information may be used as evidence.

The scope of BS10008 covers:

- The management of the availability of electronic information over time.
- Electronic identity verification, including the use of electronic signatures and electronic copyright systems, as well as the linking of electronic identity to particular electronic information.

3.7 **eNotes**
This is the Trust's archive electronic document management system holding some archived scanned patient health records. The Trust held the BS10008 certification when the scanning of these records took place which ensures the authenticity and integrity of the information.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **Chief Executive**
Responsibility for Records Management within the Trust rests with the Chief Executive. 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.

4.2 **The Senior Information Risk Owner (SIRO)**

The SIRO is the Senior Management Board Member responsible for Information Governance (IG) in the Trust and provides assurance and advice to the Board on the Trust's position on IG and information risk. The SIRO also has responsibility for the NHS Information Governance (IG) risk assessment and management processes within the Trust. In the Trust the SIRO is the Medical Director.

The SIRO will also ensure that the Board and the Accountable Officer (CEO) are kept up to date on all information risk issues.

4.3 **Caldicott Guardian**

The Caldicott Guardian is a senior clinician who oversees the arrangements for the use and sharing of clinical information and advises on options for the lawful and ethical processing of information as required and represents confidentiality issues at Board level.

4.4 **Information Governance Steering Group**

The IGSG is the senior committee in the Trust responsible for ensuring Trust compliance with Information Governance. This includes legal and NHS policy requirements. The IGSG oversees development and approval of appropriate policies and procedures for ensuring a robust framework is in place to maintain confidentiality and data security. It is chaired by the SIRO and includes the Caldicott Guardian and representation from clinical staff, health records and Information Governance areas. It reports to the Safety and Risk Committee and ultimately to the Board. In respect of Records Management it exercises this function through its sub-group, the Records Management Group.

4.4 **The Records Management Group**

The Information Governance Steering Group is responsible for ensuring that this policy is implemented and that the records management system and processes are developed, co-ordinated and monitored.

4.5 **Patient Records Manager (PRM)**

The PRM is responsible for the overall development and maintenance of health records management practices throughout the Trust, to ensure the easy, appropriate and timely retrieval of patient information; for drawing up guidance for good records management practice, promoting compliance with this and related policies and to provide advice and guidance on records management throughout the Trust.

4.6 **Information Governance Manager (IGM)**

The IGM is responsible for the overall development of Information Governance practices throughout the Trust and compliance with these practices and related policies.

4.7 **Managers**

Responsibility for corporate records management is devolved to the relevant directors, divisional managers and departmental managers. Heads of Departments, other units and business functions within the Trust have overall responsibility for management of records generated by their activities. Departmental Managers are responsible for ensuring a designated individual or individuals is/are responsible for ensuring that records controlled within their unit are managed in accordance with this policy and other relevant Trust policies.

4.8 **All Staff**

All Trust staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. 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. All staff must ensure that they undertake the appropriate record management training in accordance with their ESR Compliance Matrix.

5. POLICY STATEMENT

5.1 It is the policy of the Trust that:

- Records are available when needed. They should provide a clear record of past activities.
- Records can be accessed. This must be straightforward and the current version must be identifiable.
- Records can be interpreted. The context of a record must be clearly shown and able to be interpreted. The record should also show who created or added to it and when, during which process, and how the record relates to other records.

- Records need to be able to be trusted. They m ust reliably represent the information that was used in, or created by, the business process, and its integrity and authenticity must be able to be demonstrated.
- Records can be maintained through time. Availability, accessibility, interpretation and trustworthiness must be maintained through the record life cycle, perhaps permanently.
- Records are secure from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled audit trails will track all use and changes.
- Records are retained and disposed of appropriately using consistent and documented retention and disposal procedures, including provision for appraisal and permanent preservation of records with archival value.
- Staff are trained and made aware of their responsibilities for record-keeping and record management.

6. RECORD CREATION

6.1 Each Division should have a process for documenting its activities, taking into account the legislative and regulatory environment in which it operates.

6.2 All records should be complete and accurate:

- To allow staff to undertake appropriate actions in the context of their responsibilities.
- To facilitate audit.
- To protect legal and other rights of the organisation, patients, staff and other people affected. To show proof of validity and authenticity.

6.3 Records should be arranged in a system to provide quick and easy retrieval.

6.4 The record keeping system (paper or electronic) should be easily understood and include a documented set of rules for recording the following:

- Reference
- Title
- Index
- Protective marking for security and privacy restrictions

7. RECORD QUALITY

7.1 All Trust staff should be fully trained in record creation, use and maintenance, including having a clear understanding of:

- What they are recording and how it should be recorded
- Why they are recording it
- How to validate information with the patient or carer or other records to ensure they are recording the correct data

- How to identify, report and correct errors
- The use of the information collected and recorded
- What records are used for and the importance of timeliness, accuracy and completeness
- How to update and add information from other sources

7.2 All Trust staff should be familiar with the Trust Data Quality Policy.

7.3 All Trust staff should be fully trained in record creation, use and maintenance, including having a clear understanding of:

- What they are recording and how it should be recorded
- Why they are recording it
- How to validate information with the patient or carer or other records to ensure they are recording the correct data
- How to identify, report and correct errors
- The use of the information collected and recorded
- What records are used for and the importance of timeliness, accuracy and completeness
- How to update and add information from other sources

8. RECORDS MAINTENANCE AND TRANSPORTATION

8.1 All Trust staff should ensure that records including person-identifiable data (PID), or other Trust confidential records, are used and transferred in accordance with the Trust's. The transfer of Casenotes must comply with the Trust's Health Records Policy. The transfer of records containing person-identifiable and/or confidential data, must be done safety and securely in sealed envelopes/bags which are clearly marked as Private & Confidential.

The movement and location of records must be controlled to ensure that:

- Records are easy to retrieve
- Outstanding issues can be dealt with
- there is an auditable trail of record transactions

8.2 Storage accommodation for current records should:

- Be clean and tidy
- Prevent damage to records
- Provide a safe and secure area to staff to work in

8.3 For records in digital format, maintenance in terms of back-up and planned migration to new platforms should be designed and scheduled to ensure continuing access to readable information.

8.4 Equipment storing current records should:

- Provide safe and secure storage preventing unauthorised access
- Meet health, safety and fire regulations
- Allow appropriate accessibility

8.5 A business continuity plan to provide protection for all types of records is vital to the continued functioning of the organisation. This should be maintained and rehearsed annually in accordance with the Business Continuity Management Policy.

8.6 Information Governance staff can arrange for expert advice from appropriate sources on:

- Environmental hazards to records.
- Assessment of risk to records.
- Business continuity and other considerations related to records.

9. ELECTRONIC DOCUMENT MANAGEMENT (EDM) SYSTEM FOR ARCHIVE HEALTH RECORDS

9.1 The Trust undertook the scanning of archive paper health records into an electronic format accessible in the eNotes system.

9.2 In order to protect the evidential value by copying and storing the record the Trust was certificated during the scanning process with the British Standard BS 10008.

9.3 The scanning of paper health records has ceased but records stored on the EDM solution are managed in accordance the NHS Records Management Code of Practice.

10. RECORDS INVENTORY (INFORMATION ASSET REGISTER)

10.1 The Trust has established an Information Asset Register through which departments and other units can register the records they are maintaining. This inventory of record collections facilitates:

- the classification of records into series; and
- the recording of the responsibility of individuals creating records

10.2 This inventory will be sent out and reviewed annually.

11. RETENTION AND DISPOSAL SCHEDULES

11.1 It is a fundamental requirement that all of the Trust's records are retained for a minimum period of time for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's business functions.

11.2 The Trust has adopted the retention periods set out in the Records Management NHS Code of Practice for Health & Social Care. Although this Code of Practice contains a comprehensive list in regards to record type and category in the retention schedules, it is not possible to list every type. Where a record type is not listed advice should be sought from the Patient Records Manager.

11.3 It is particularly important under the Freedom of Information Act 2000 that disposal of records is undertaken in accordance with clearly established Trust policies.

11.4 When information is held in an electronic format on a system, the minimum retention period should be reviewed and a decision made that of the archival value of the information on the system before it is destroyed. Records may be kept for longer than the minimum retention periods on electronic clinical systems.

12. APPRAISAL OF RECORDS

12.1 Appraisal refers to the process of determining if records are: Worthy of permanent archival preservation

- To be retained for a longer period if they are still in use
- To be destroyed

12.2 Records should be appraised at the appropriate time following referral to the NHS Records Management: Code of Practice – Retention Schedule for recommended minimum retention period.

12.3 Advice should be sought from the Patient Records Manager for any records requiring permanent preservation who will seek advice from the national archives.

12.4 All disposal decisions following appraisal must be clearly recorded on the Annual Inventory of Records for that area and submitted to the Information Governance Office.

13. RECORD CLOSURE

13.1 Record closure is making a record inactive and transferring it to secondary storage.

13.2 Records must be closed as soon as they have ceased to be in active use other than for reference purposes.

13.3 Where possible all closed records (electronic or paper) must be marked 'closed' and display a "date of closure' on the record itself as well as in the index or database of the files and folders.

13.4 Where possible information on the intended disposal of electronic records should be included in the metadata when the record is created.

13.5 All closed records must be stored in a safe and secure environment in an organised system.

14. CLASSIFICATION MARKING OF NHS INFORMATION

The NHS has yet to adopt a national classification marking system for all NHS records, corporate and clinical. Until such a system is adopted the Trust marks patient records data as "CONFIDENTIAL", emphasizing the greater restrictions applicable to sensitive personal data and the need to limit access in accordance with the Data Protection Act 1998 and the Caldicott Principles – link to be added once Caldicott page on Hub is live

15. RECORDS MANAGEMENT SYSTEMS AUDIT

15.1 The Trust will ensure audits of its records management practices are carried out, in compliance with this framework. The results will be fed back to the Records Management Group who will provide a report to the Information Governance Steering Group.

15.2 The audits will:

- Identify areas of operation that are covered by the Trust's policies and identify which procedures and/or guidance should comply to the policy;
- Follow a mechanism for adapting the policy to cover missing areas if they are critical to the creation and use of records, and use a subsidiary development plan if there are major changes to be made
- Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance; and
- Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

16. RECORDS AT CONTRACT CHANGE – CARE RECORDS

16.1 When a contract ends, a service provider retains liability for the work they have done, at any change of contract the records must be retained until the time period for liability has expired.

16.2 The standard NHS contract contains an option to allow the commissioner to direct a transfer of care records to a new provider for continuity of service and this includes third parties and those working under any qualified provider contracts. This will usually be to ensure the continuity of service provision upon termination of the contract. After the contract period has ended the previous provider will remain liable for their work. In this instance there may be a need to make the records available for continuity of care or for professional conduct cases.

17. TRAINING

17.1 All Trust staff will be made aware of their responsibilities for record-keeping a nd record management at the Trust Induction through generic and specific training programmes and guidance provided by the local Records Lead and led by the Health Records Manager and by the Information Governance Manager.

17.2 Records Management training is now mandatory for all staff who handle records, including creation, use, management, storage, disposal and selection for permanent preservation. Staff should use their ESR Compliance Matrix to identify whether they are required to undertake Records Management Training and which e-learning package is appropriate. Compliance will be monitored by the Information Governance Manager and reported to the IGSG.

18. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author, the Patient Records Manager in the Health Records Department of the Information Management and

Technology Directorate (IM&T). An electronic copy will be maintained on the Trust Intranet (A-Z) – P – Policies (Trust-wide) – R – Records Management. Archived copies will be stored on the Trust's "archived policies" shared drive and will be held indefinitely. A paper coy, where one exists, will be held for 10 years.

19. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

19.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by
1.	Compliance at Level 2 with IG toolkit for items in the Corporate Records Assurance, namely:	Internal Audit and Self-assessment
2.	Adherence to retention and disposal schedules Management checks authorised by and reported to the Record Management Group	Reports to and minutes of the Records Management Group
3.	Record quality - DQIF reports on data quality	Reports to and minutes of DQIF
4.	Audit checks on documents as part of annual document audit	Annual clinical document check
5.	Annual record inventory for corporate records	Reports by managers to IG Office and minutes and report to IGSG
6.	BS10008 compliance	Self-assessment prior to accreditation by BSI assessor or similar.

19.2 **Frequency**

In each financial year, a formal report will be written and presented by the IG Manager at the Information Governance Steering Group for onward reporting to the Safety and Risk Committee.

19.3 **Undertaken by**

Reports to the IGSG will be written by the Chair of the Records Management Group.

19.4 **Dissemination of Results**

At the Information Governance Steering Group which is held bi-monthly and at the Safety and Risk Committee.

19.5 **Recommendations/ Action Plans**

Implementation of the recommendations and action plan will be monitored by the Information Governance Steering Group which meets bi-monthly.

19.6 Any barriers to implementation will be risk-assessed and added to the risk register.

19.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

20. REFERENCES

Access to Health Records Act 1990:
http://www.legislation.gov.uk/ukpga/1990/23/contents

Computer Misuse Act 1990:
http://www.legislation.gov.uk/ukpga/1990/18/contents

Criminal Procedure and Investigations Act 1996:
http://www.legislation.gov.uk/ukpga/1996/25/contents

Data Protection Act 1998 (DPA98):
http://www.legislation.gov.uk/ukpga/1998/29/contents

Environmental Information Regulations 2004 (Statutory Instrument 2004/No 3391) (EIR): http://www.legislation.gov.uk/uksi/2004/3391/contents/made

Freedom of Information Act 2000 (FOIA):
http://www.legislation.gov.uk/ukpga/2000/36/contents

Human Rights Act 1998: http://www.legislation.gov.uk/ukpga/1998/42/contents

Regulation of Investigatory Powers Act 2000 (RIPA):
http://www.legislation.gov.uk/ukpga/2000/23/contents

NHS Confidentiality Code of Practice, Department of Health, November 2003,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document s/digitalasset/dh_4069254.pdf

NHS Information Security Management, Department of Health, April 2007 http://systems.hscic.gov.uk/infogov/codes/securitycode.pdf

NHS Information Risk Management, Digital Information Policy, NHS Connecting for Health, January 2009:
NHS Records Management: Code of Practice 2016 for health and social care
https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care
Data Handling Procedures in Government: Final Report. Cabinet Office, June 2008
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60966/
final-report.pdf

Guidance on the use of the business impact level tables. Cabinet Office, March 2009 http://media.wix.com/ugd/796a35_329b29f430ccc359ec3584e304c6704d.pdf

Privacy Impact Assessment Handbook 2.0, Information Commissioner's Office,
http://www.ico.gov.uk/upload/documents/pia_handbook_html_v2/html/6-step2.html Connecting for Health – Information Governance www.cfh.ig

Institute of Health Records and Information Management

APPENDIX 1: COMMUNICATION PLAN

Royal Devon and Exeter NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All staff
The key changes if a revised policy/strategy	Update on Destruction and Retention Criteria Information on patient care records at contract change.
The key objectives	The aims of the Records Management Policy are to ensure: A systematic and planned approach to records management ensuring standardisation across the Trust covering records creation, storage and disposal in line with National Standards and legislation Efficient and best value through improvements in the quality and flow of information and greater co-ordination of records and storage systems to ensure where possible best practice is shared and duplication avoided An active destruction, retention and archiving policy for all administrative records to ensure records are destroyed when they are no longer required Training and awareness of the records management programme with appropriate staff groups to ensure they are aware of their responsibilities
How new staff will be made aware of the policy and manager action	Local induction process
Specific Issues to be raised with staff	Overall awareness of records management
Training available to staff	On line training available via NHS Digital
Any other requirements	
Issues following Equality Impact Assessment (if any)	No negative impacts
Location of hard / electronic copy of the document etc.	On the Trust's Intranet site

APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	RECORDS MANAGEMENT POLICY
Division/Directorate and service area	IM&T/Health Records

Name, job title and contact details of person completing the assessment	[redacted]
Date completed:	xx/xx/20xx

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To provide the Trust strategy and policy on Records Management.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☐ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☐	☒
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

N/A

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

This policy is for staff on how Records should be managed within the Trust and the Trust's overall strategy on Records Management. The management of Health Records is a separate policy called the Health Records Policy.

The Records Management Policy provides guidance to ensure staff can handle, transfer and manage the records they deal with and therefore it meets human rights obligations.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	*Age/sex/religion etc.*
Issue:	*Missed opportunity that has been noted*
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Royal Devon and Exeter
NHS Foundation Trust

JOB DESCRIPTION

JOB DETAILS	
Job Title	Digital Healthcare Records Manager
Reports to	Head of Information Management
Band	Band
Department/Directorate	Digital Healthcare Records / Digital Services

JOB PURPOSE

To be responsible for the operational management of the Digital Records Department and delivery of a high quality and effective service to its users

To ensure the department adheres to the standards contained in the Trust's Healthcare Records Policies

To develop and maintain systems and processes to ensure quality standards are set and met in line with the Trust's governance framework

To encourage and support the personal and professional development of staff

KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

Manage the digital records department on a day to day basis, ensuring the continuity of service at all times

Provide leadership and guidance to all members of the department

Ensure all staff are trained appropriately for their roles

Ensure that patient clinical records are available to clinical staff when required

KEY WORKING RELATIONSHIPS

No. of Staff reporting to this role: approx. 44 staff

The post holder is required to deal effectively with staff of all levels throughout the Trust as and when they encounter on a day to day basis

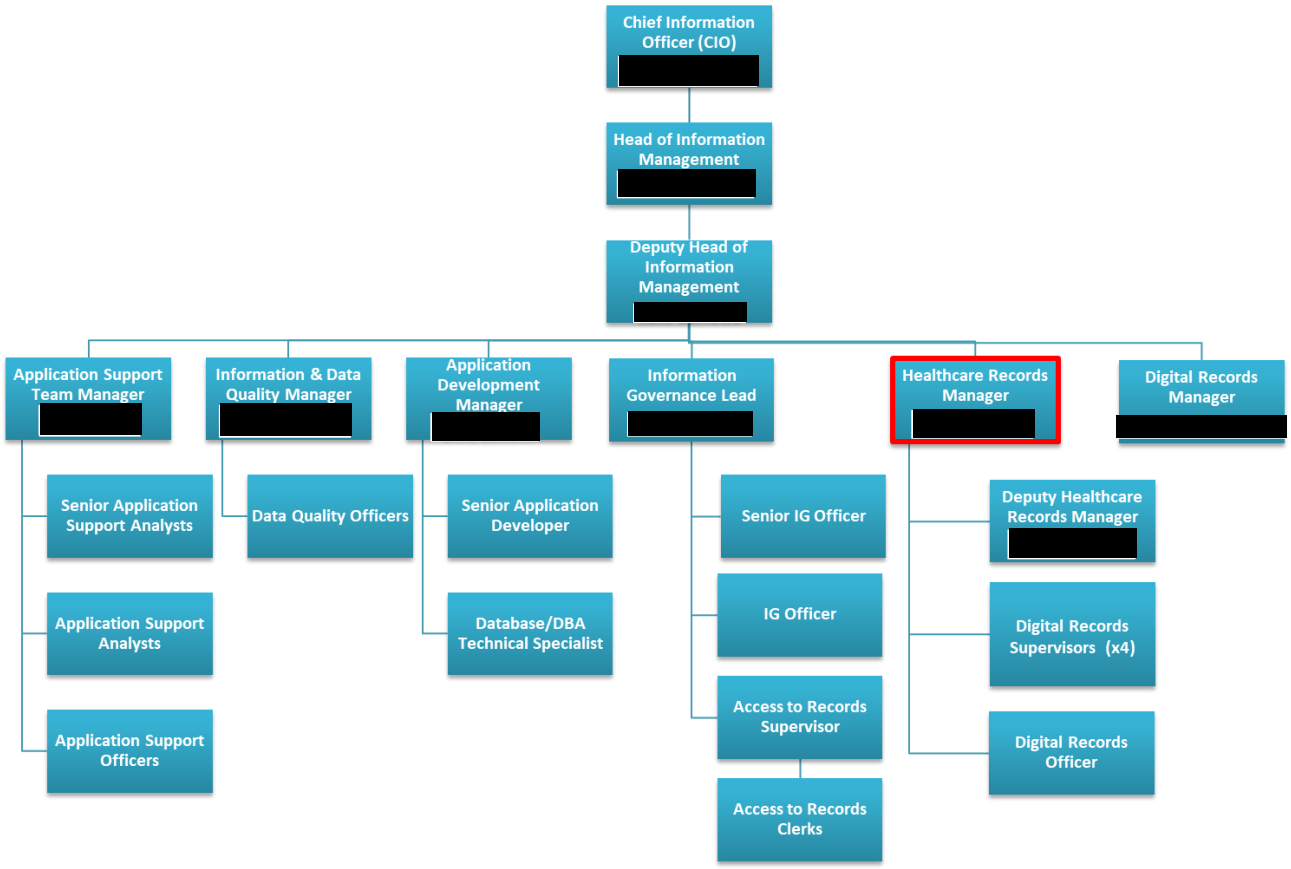
In addition, the post holder will deal with the wider healthcare community, external organisations and the public.

This will include verbal, written and electronic media.

Of particular importance are working relationships with:

Internal to the Trust	External to the Trust
• Chief Information Officer • Head of Information Management • Assistant Digital Healthcare Records Manager • Clinicians and their teams • Divisional Staff • Clerical and administrative staff • All wards and departments	• GP Practices • Other Hospitals • Police • Solicitors • Patients • Training and workshop Providers

ORGANISATIONAL CHART



FREEDOM TO ACT

The post holder decides how results are best achieved. The post holder will make strategic plans for the operation of the department.

COMMUNICATION/RELATIONSHIP SKILLS

The post holder will be required to manage complex communication with people on complex matters on a daily basis.

To ensure the creation, maintenance and review of Safety Systems of Working and to ensure that all departmental staff are fully conversant with them

To maintain the integrity and reputation of the department by effective and harmonious attitudes and relationships with patients, colleagues and hospital personnel. Likely to involve handling and conveying

of complex information and/or distressing situations, eg; difficult conversations with staff in relation to performance issues.

To update and maintain the Trusts' Major Incident Call Out List for the department and ensure regular tests are undertaken

To contribute to the maintenance of an effective communication with the department and to users of the service

To attend and actively participate in HODs/Trustlink, Speciality Team and Directorate activities as required.

To be a point of contact for staff, outside organisations and the general public with regard to healthcare records issues

ANALYTICAL/JUDGEMENTAL SKILLS

The postholder will be required to make judgements on a range of facts that require analysis and comparison of a range of options regularly

To ensure the formal reporting of incidents and take follow-up remedial action

To co-ordinate the investigation and resolution of complaints and consider suggestions for improvements to the service

To monitor the Trust's ability to meet the record management needs of clinicians and health professionals and to act or make recommendations as necessary

PLANNING/ORGANISATIONAL SKILLS

The postholder will be required to plan and organise complex on-going activities

Participate in the development of the department objectives and operational processes

To plan and implement storage solutions, with particular reference to archive records

To fully liaise with the multi-disciplinary team and identify clinical risks. An action plan to control the clinical risks should be jointly developed with the senior team. To monitor and follow-up incident reports ensuring any necessary action is taken.

PATIENT/CLIENT CARE

Incidental contact, provide non-clinical advice.

Basic information provided in accordance with current legislation - provide advice and guidance to patients relatives on non-clinical issues

POLICY/SERVICE DEVELOPMENT

To assist in the development, implementation and monitoring of Trust policies and procedures for the Digital Records department

To maintain and develop an awareness of all relevant Trust policies related to Human Resource, Occupational Health, Governance and Health & Safety issues

To liaise with Trust staff to set and monitor relevant quality standards and to support the maintenance of these standards across the Trust.

To ensure that the Trust's policies on Confidentiality and Health & Safety are observed at all time by departmental staff

Have an understanding of GDPR, Data Protection Act 2018 and the Records Code of Conduct in order to advice and guide Digital Records staff and other stakeholders. Liaise with the Information Governance Team and Medical Director where necessary

FINANCIAL/PHYSICAL RESOURCES

To ensure the department is managed within it's budgetary allocation

To comply with Trust standing orders, Standing Financial Instructions and adhere to Trust policies and procedures at all times

Safe use of equipment other than equipment used personally

HUMAN RESOURCES

The post holder will be responsible for interviewing and appointment of department staff. Will undertake appraisals, 1:1's and disciplinary matters.

To be responsible for the training of departmental personnel and ensure that staff routinely attend all statutory training as required by the Trust

To ensure on-going personal and professional development in relation to the delivery of Digital Records department services

To hold regular departmental meetings in an atmosphere which encourages staff to put forward information and suggestions for improvement

To create and develop a learning environment for all departmental staff to ensure that the Digital Records service is delivered by a competent and appropriately trained workforce.

To undertake regular development reviews with staff with development of personal development plans

To co-ordinate the training and development needs of staff to ensure the team is equipped to fulfil the needs of the service and that individuals have equitable access to development opportunities

To encourage and allow development of all staff in aspects of information technology to enable them to use relevant IT systems

INFORMATION RESOURCES

Develop, improve and implement effective systems for the safe custody, confidentiality and proper maintenance of all patient and staff records

Input and appropriately manipulate data on the Trust and National systems, eg; relevant data changes on the Spine and on the Patient Administration System. Keyboard skills will require accuracy rather than speed

RESEARCH AND DEVELOPMENT

Lead on the department's programme of audit, and support the assistant digital healthcare records manager to improve the tracking, filing, scanning and quality of healthcare records both within the department and throughout the Trust

Liaise with wider Trust staff with respect to findings of audits and implement support/training as required to achieve improved results

Regularly support the wider Trust request for patient notes for clinical audit and research purposes

Participate in audit and produce action plans where appropriate to improve identified areas of practice

PHYSICAL SKILLS

Physical skills obtained through practice/developed physical skills;

Standard keyboard skills for regular use of computer systems, eg; Patient Administration System

PHYSICAL EFFORT

Combination of sitting, standing, walking/frequent sitting or standing in restricted position

Moderate effort for several short periods – pushing or trollies with patients notes, retrieving patient notes from storage

Lifting, sorting, filing, general handling of case notes

Occasionally help to move case note files and other equipment or work in confined areas where case notes are stored. This may involve dusty environments eg; where end-of-lifecycle notes stored for 8 years are retrieved for destruction

MENTAL EFFORT

Regularly multi-tasks in constantly changing environment to maintain required standards and continuity of service

EMOTIONAL EFFORT

Occasional distressing or emotional circumstances, dealing with distressed staff, patients or relatives

Provides emotional support to the departmental team

Provides leadership and support to subordinate members of the team.

Resilient and calm under pressure

WORKING CONDITIONS

Occasional unpleasant conditions specifically heat. Dusty conditions in archive storage area; verbal aggression (patients).

OTHER RESPONSIBILITIES

Take part in regular performance appraisal.

Undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling

Contribute to and work within a safe working environment

You are expected to comply with Trust Infection Control Policies and conduct yourself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

You must also take responsibility for your workplace health and wellbeing:

- When required, gain support from Occupational Health, Human Resources or other sources.
- Familiarise yourself with the health and wellbeing support available from policies and/or Occupational Health.
- Follow the Trust's health and wellbeing vision of healthy body, healthy mind, healthy you.
- Undertake a Display Screen Equipment assessment (DES) if appropriate to role.

APPLICABLE TO MANAGERS ONLY

Leading the team effectively and supporting their wellbeing by:

- Championing health and wellbeing.
- Encouraging and support staff engagement in delivery of the service.
- Encouraging staff to comment on development and delivery of the service.
- Ensuring during 1:1's / supervision with employees you always check how they are.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

Everyone within the Trust has a responsibility for, and is committed to, safeguarding and promoting the welfare of vulnerable adults, children and young people and for ensuring that they are protected from harm, ensuring that the Trusts Child Protection and Safeguarding Adult policies and procedures are promoted and adhered to by all members of staff.

Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust continue to develop our long-standing partnership with a view to becoming a single integrated organisation across Eastern and Northern Devon. Working together gives us the opportunity to offer unique and varied careers across our services combining the RD&E's track record of excellence in research, teaching and links to the university with NDHT's innovation and adaptability.

PERSON SPECIFICATION

Job Title	Digital Healthcare Records Manager

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING	Degree level or equivalent Evidence of Continuous Professional Development (CPD)	
KNOWLEDGE/SKILLS	Excellent verbal and written communication Proven leadership ability Change management Understanding of individual and corporate responsibilities towards Health & Safety The application of clinical governance in practice Knowledge of Information Governance issues relating to Healthcare Records Details knowledge of Healthcare Records related IT systems Must be IT proficient	
EXPERIENCE	Healthcare records department experience at supervisor level or above Leadership and management experience Resource management Risk management	
PERSONAL ATTRIBUTES	Ability to meet targets and work to deadlines Regularly able to multi-task in a constantly changing environment Negotiating skills Resourceful and innovative Be resilient and calm under pressure Provide leadership and support to subordinate members of the team	

	Provide emotional support to the departmental team Able to work as a team member	
OTHER REQUIREMENTS	The post holder must demonstrate a positive commitment to uphold diversity and equality policies approved by the Trust. Ability to travel to other locations as required. Demonstrate a high level of commitment to personal/professional development and to maintain a working knowledge of current healthcare records practices	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	Y		X		
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	N				
Electrical work	N				
Physical Effort	Y		X		
Mental Effort	Y			X	
Emotional Effort	Y			X	
Working in isolation	Y		X		
Challenging behaviour	Y			X	

Royal Devon and Exeter
NHS Foundation Trust

JOB DESCRIPTION

JOB DETAILS	
Job Title	Assistant Digital Healthcare Records Manager
Reports to	Digital Healthcare Records Manager
Band	Band 5
Department/Directorate	Digital Records – Digital Services

JOB PURPOSE

To provide business support, administrative leadership and general office management to deliver a high quality, comprehensive Digital Healthcare Records service.

The post holder will be responsible for their own workload, including having responsibility for financial and personnel administration, overseeing the day to day activities of staff and dealing with clients/visitors and multi-disciplinary teams.

To support and deputise for the Digital Healthcare Records Manager

To ensure the smooth and efficient running of the Digital Records department is adhered to at all times.

Maintains and improves data quality with respect to the location and quality of patient records.

KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The Assistant Digital Healthcare Records Manager will be based in the Digital Records department and will provide business support to the department by ensuring patient records are available for appointments, admissions and are delivered to the relevant areas in a timely manner.

To lead on a programme of audit to ensure patient records are in the correct locations, filed and tagged correctly.

The post holder will fulfil all administration tasks and work as part of a team and has responsibility for directing the workload for the supervisors and the day to day supervision of staff.

Ensures the provision of on the job training to staff within the department.

KEY WORKING RELATIONSHIPS

No. of Staff reporting to this role: 4 supervisors, and indirectly 40 records staff

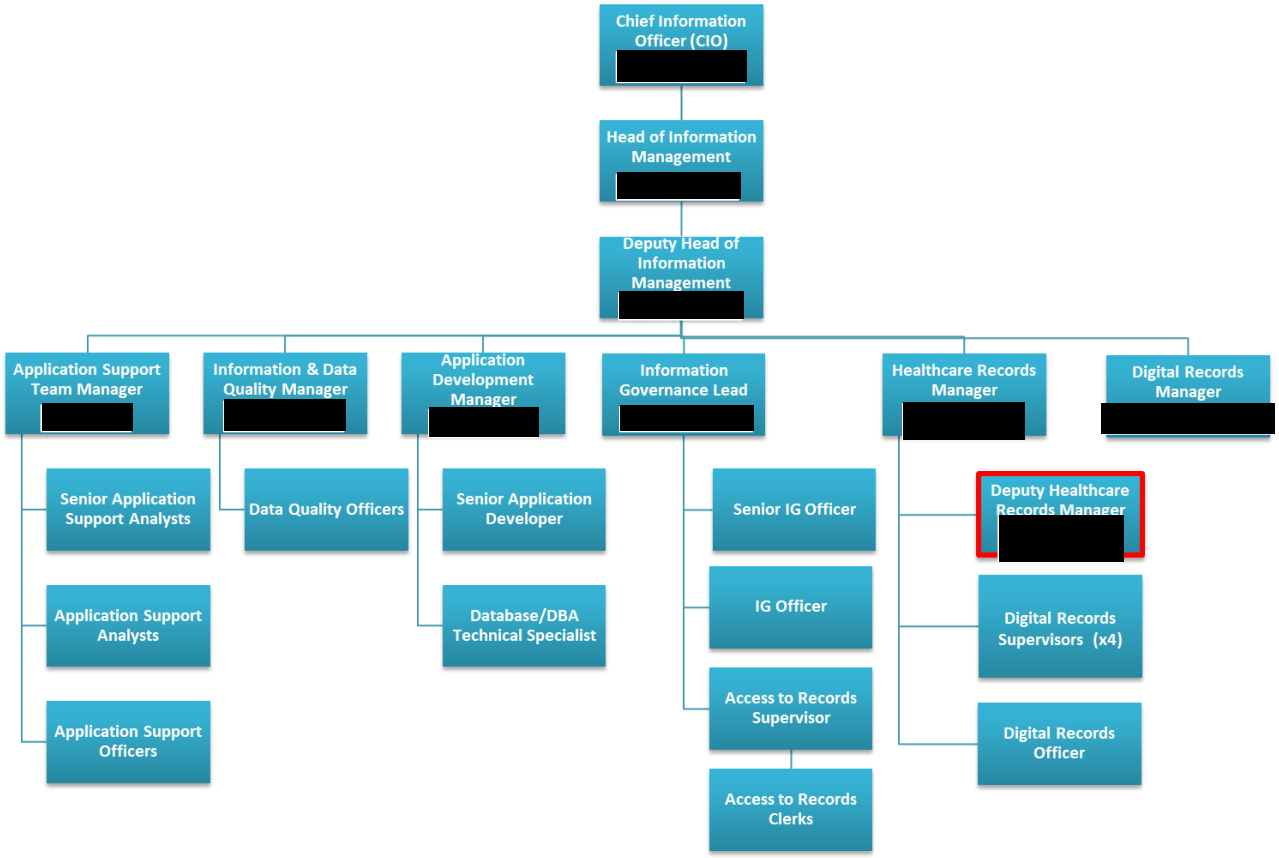
The post holder is required to deal effectively with staff of all levels throughout the Trust
the wider healthcare community, external organisations and the public.

This will include verbal, written and electronic media. In all instances this shall be carried out in line with the Trusts ‘Visions and Values’ policy with particular adherence to Excellence, Integrity and Support of the wider Digital Services team

Of particular importance are working relationships with:

Internal to the Trust	External to the Trust
• Chief Information Officer • Head of Information Management • Digital Healthcare Records Manager • Clinicians and their teams • Divisional Staff • Clerical and administrative staff • All wards and departments	• GP Practices • Other hospitals • Police • Solicitors • Patients • Training and workshop Providers

ORGANISATIONAL CHART



FREEDOM TO ACT

Work is managed rather than supervised. The post holder will make decisions daily regarding operational practice; this will often require assessment of options with conflicting priorities

COMMUNICATION/RELATIONSHIP SKILLS

Ensure supervisors have the relevant skills and knowledge required to carry out their roles and responsibilities within the department

Work with all teams and Digital Healthcare Records Manager to develop the service and improve and maintain an excellent department reputation

Liaise with other staff and departments to ensure that the Digital Records department is delivering a timely and professional service

Daily engagement and co-ordination with the supervisors in delivering department KPI's

In collaboration with the Digital Healthcare Records Manager, assist and guide the team by offering advice and making decisions around complex or excessive access requests, using specialist knowledge including Healthcare Records, GDPR and Data Protection legislation, and liaise with the information Governance team as appropriate

Assist with answering complaints about the service from patients and clients should any arise Communicate with colleagues via a variety of media (eg email, in person, by phone)

Help to devise/develop and implement communication strategies between the Digital Records staff and service users

Answer queries from staff, patients, their relatives and external stakeholders, often without notice, thereby interrupting the flow of work. This may involve handling and conveying complex information and/or distressing situations, eg; a request for notes and queries for or from patients/relatives involving life-changing accidents and/or terminal illness

Liaise with departments throughout the Trust with respect to supporting the patient journey (including clinic management, out-patients, application support etc)

ANALYTICAL/JUDGEMENTAL SKILLS

Review with supervisors the workloads where pressures exist and mitigate or resolve those pressures using problem solving and analytical skills

Analyse, investigate and resolve issues/queries relating to Digital Records processes and access requests and assist with updating incidents notified via Datix as appropriate.

Locates lost case notes, provides advice and guidance to staff on disclosure of information in accordance with current legislation

Ensure information required for reporting is being collected in a timely and accurate manner according to defined requirements to enable the Digital Healthcare Records Manager to provide KPI's to the wider organisation. This will require concentration to ensure required data is complete and accurate, but may involve frequent, unpredictable interruptions

PLANNING/ORGANISATIONAL SKILLS

Assist in the delivery of department objectives, ie the provision of the Digital Records service in a timely and professional manner, in line with departmental procedures

Have daily oversight of the work of each team, co-ordinating and adjusting where necessary using knowledge of the various processes and functions of the Digitial Records department and wider Trust.

Assess, plan and organise the workload of the supervisors on a weekly or daily basis as needed, ensuring equal and equitable distribution as far as is practicable

Ensure operational processes are reviewed regularly within an on-going planning process

Liaise and work with clinical colleagues and department managers to improve and review practice as an when required

Judge which issues need escalation and action appropriately. This may involve assessing a range of options to determine the best course of action

PATIENT/CLIENT CARE

Incidental contact, provide non-clinical advice.

Basic information provided in accordance with current legislation provide advice and guidance to patients and relatives on non-clinical issues.

POLICY/SERVICE DEVELOPMENT

Support the Trust's overarching Digital Strategy

Participate in the development of appropriate system downtime plans, considering disaster recovery guidelines and ensure that they are up to date

Actively participate in and support the department's BSI 10008 compliance accreditation

Work with the Digital Healthcare Records Manager to ensure an effective case note service is provided in line with the Trust's retention and destruction policy

Help to document and implement processes and produce guidance for staff, working with teams to develop and maintain SOPs (Standard Operating Procedures)

With the Digital Healthcare Records Manager, provide input into the development of Digital Records policies and procedures as required utilising specialist knowledge or relevant legislation and guidance

Identify where improvements to existing policies and working practices within and outside the department can be made, suggest changes and implement these in liaison with line manager and other departments where relevant

Awareness of GDPR, Data Protection Act 2018 and the Records Code of Conduct in order to advise and guide Digital Records staff and other stakeholders; liaise with the Information Governance Team and the Medical Director where necessary

Provide advise and guidance to service users using specialist knowledge of department processes and relevant Healthcare Records legislation

FINANCIAL/PHYSICAL RESOURCES

Oversee and sign off ordering of supplies as needed

Be an authorised signatory for signing off travel expenses, overtime, bank staff, orders and minor works requisitions (up to a maximum of £5,000)

Safe use of equipment other than equipment used personally

HUMAN RESOURCES

Daily line management of the Digital Records Supervisors and Digital Records Clerks

Undertake routine performance management and sickness absence procedures as per Trust policies. This will occasionally involve distressing circumstances eg; capability or conduct management or sickness absence reviews

Undertake staff appraisals with supervisors

Ensure supervisors are undertaking appraisals with their own teams and arrange training required where necessary, ensuring any barriers to understanding are addressed.

Assist with recruitment of new staff

Supervision and mentorship of new staff, ensuring supervisors are providing the relevant training and induction across the range of Digital Records established procedures and functions

INFORMATION RESOURCES

Develop, improve and implement effective systems for the safe custody, confidentiality and proper maintenance of all patient and staff records

Input and appropriately manipulate data on the Trust and National systems, eg; relevant data changes on the Spine and on the Patient Administration System. Keyboard skills will require accuracy rather than speed

RESEARCH AND DEVELOPMENT

Lead on the department's programme of audit, and support the audit supervisor in improving the tracking, filing, scanning and quality of healthcare records both within the department and throughout the Trust

Liaise with wider Trust staff with respect to findings of audits and implement support/training as required to achieve improved results

Regularly support the wider Trust request for patient notes for clinical audit and research purposes

PHYSICAL SKILLS

Physical skills obtained through practice/developed physical skills;

Standard keyboard skills for regular use of computer systems, eg; Patient Administration System

PHYSICAL EFFORT

Combination of sitting, standing, walking/frequent sitting or standing in restricted position

Moderate effort for several short periods – pushing or trollies with patients notes, retrieving patient notes from storage

Lifting, sorting, filing, general handling of case notes

Occasionally help to move case note files and other equipment or work in confined areas where case notes are stored. This may involve dusty environments eg; where end-of-lifecycle notes stored for 8 years are retrieved for destruction

MENTAL EFFORT

Concentration while preparing case notes and letters/dealing with frequent interruptions and competing demands from staff or work-related queries during each shift

EMOTIONAL EFFORT

Occasional distressing or emotional circumstances, dealing with distressed patients/relatives/staff

WORKING CONDITIONS

Occasional unpleasant conditions specifically heat. Dusty conditions in archive storage area; verbal aggression (patients).

OTHER RESPONSIBILITIES

Professional responsibilities
Ensure staff adhere to professional standards and codes of conduct (including self)
Ensure staff adhere to Trust policies and procedures (including self)
Ensure staff are compliant with mandatory training (including self)
Maintain training records for staff

Education and development responsibilities
Ensure all staff have attended their mandatory training
Ensure staff are trained appropriately for their role and are able to cross-cover at least one other function within their team or the department
Participate in or undertake training needs analysis

Link with other organisations to facilitate education of self/others
Ensure yearly appraisal occurs for self and others

Undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling

Contribute to and work within a safe working environment

You are expected to comply with Trust Infection Control Policies and conduct yourself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

You must also take responsibility for your workplace health and wellbeing:

- When required, gain support from Occupational Health, Human Resources or other sources.
- Familiarise yourself with the health and wellbeing support available from policies and/or Occupational Health.
- Follow the Trust's health and wellbeing vision of healthy body, healthy mind, healthy you.
- Undertake a Display Screen Equipment assessment (DES) if appropriate to role.

APPLICABLE TO MANAGERS ONLY

Leading the team effectively and supporting their wellbeing by:

- Championing health and wellbeing.
- Encouraging and support staff engagement in delivery of the service.
- Encouraging staff to comment on development and delivery of the service.
- Ensuring during 1:1's / supervision with employees health and wellbeing is discussed.

GENERAL

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PERSON SPECIFICATION

Job Title	Assistant Digital Healthcare Records Manager

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING	Good general educational standards 4 GCSE's including English Supervisory qualifications (ILM etc) Degree or equivalent experience in the field of Healthcare records	Healthcare Records qualification eg IHRIM
KNOWLEDGE/SKILLS	Excellent communication skills with a variety of staff and stakeholders Excellent interpersonal skills Excellent IT skills in Microsoft Office Ability to prioritise workload for self and other staff and work on own initiative Specialist working knowledge of Health Records legislation and best practice ie GDPR, Data protection Act 2018, Records Management Code of Practice 2016 Confidentiality and data protection issues Working knowledge of BSI 10008 compliance Awareness of electronic scanning procedures, ie; prep, scan, QA, QC Working knowledge of a variety of Health Records processes and functions, eg; prep, scan, library, SARs Knowledge of related processes within an acute Trust environment, eg; coding, outpatients, admissions	Information analysis skills Recruitment & selection experience Ability to produce/write concise relevant reports Ability to work according to defined policies and procedures Problem solving, auditing and analysis skills for providing reports and resolving issues
EXPERIENCE	Previous experience in a healthcare records setting Experience of Patient Administration System applications	

	Detailed knowledge of healthcare records related IT systems Healthcare records department experience at supervise level or above Leadership and management experience	
PERSONAL ATTRIBUTES	Attention to detail Positive attitude Ability to work to tight deadlines Ability to work using own initiative Organisational skills to enable co-ordination or work across several teams and functions Prepared to learn and teach new skills to others Ability to work well as part of a team as well as ability to exercise own initiative and work independently to achieve objectives and deadlines Ability to work under pressure and to concentrate in a busy and demanding environment Ability to communicate and co-operate with staff at all levels Ability to plan and adapt to change	Motivational skills to support team members
OTHER REQUIREMENTS	To be aware of and demonstrate a positive commitment to uphold diversity and equality policies approved by the Trust Adhere to the Trust's Vision, Mission and Values Ability to travel to other locations as required Demonstrate ability to lead and work within a team Highly motivated, adaptable and flexible	

	Ability to use VDU equipment for prolonged periods in accordance with Health and Safety Regulations Dealing with constant background noise	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	Y			X	
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	Y			X	
Driving	N				
Food handling	N				
Night working	Y	X			
Electrical work	N				
Physical Effort	Y				X
Mental Effort	Y			X	
Emotional Effort	Y		X		
Working in isolation	N				
Challenging behaviour	Y		X		

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

JOB DESCRIPTION

JOB DETAILS	
Job Title	Digital Records Team Leader
Reports to	Deputy Healthcare Records Manager
Band	Band 4
Department/Directorate	Healthcare Records / Digital Services

JOB PURPOSE

The introduction of CITO, an electronic documentation management (EDM) system for Healthcare Records is a core component of the fully integrated Electronic Patient Record that the Trust envisages. When implemented, along with Epic, an electronic patient record, the current healthcare records will be transformed into an electronic form through a digitisation process that will capture an electronic image of all pages in a health record, no matter what type.

The purpose of this role is to support the digitisation of the paper record is carried out correctly and in line with our statutory obligations. Aspects of the role will include the supervision of the preparation of records for scanning into either electronic system, scanning of records accurately within either electronic system, undertaking quality assurance of scanned records and supervising the identification and preparation of notes for destruction.

The Trust will have two separate locations for this role, and the post holder will be required to work flexibly in both locations and within the four principle tasks within the department.

KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The Digital Records Supervisor will have the following key duties and responsibilities:

- To provide day to day management and supervision of the scanning bureau staff to ensure all staff undertake duties in accordance with the Trust's Healthcare Records policies and procedures
- To ensure the careful preparation of paper-based health records material to ensure that it is in good order and is suitable for electronic scanning
- To ensure the scanning of prepared documentation to the appropriate electronic system accurately, ensuring that the documentation is scanned to the correct record and electronically filed in the appropriate location
- To provide supervision for the required quality assurance activity to ensure that all scanning, including that carried out outside the department has been carried out in accordance with policies and procedures and meets our statutory obligations
- To supervise the identification and preparation of paper notes for destruction in accordance with policies and procedures, ensuring we meet our statutory obligations
- To ensure the proper recording of document information in the appropriate application to enable the audit process to be completed accurately
- To work with staff in correcting errors or discrepancies identified as part of the quality assurance checks to ensure that remedial action takes place as soon as possible and to provide learning to reduce future errors.

- To ensure if duplicate electronic medical records are identified in Epic that they are flagged to the data quality team, or in CITO raised with the system supplier so these can be corrected as soon as possible

- To carry out regular housekeeping of the two electronic systems to ensure that those records suitable for destruction under the Trusts Retention and Destruction policy are identified and appropriately deleted from the system

- To ensure that the security and confidentiality of patient's information is maintained at all times as per the Trust's confidentiality and Security of Patient Information Policy.

KEY WORKING RELATIONSHIPS

Areas of Responsibility:
Working supervision of the preparation of notes for scanning, accurate scanning of clinical information, conduct Quality Assurance of scanned notes, undertake preparation of notes for destruction

No. of Staff reporting to this role: proportion of 40

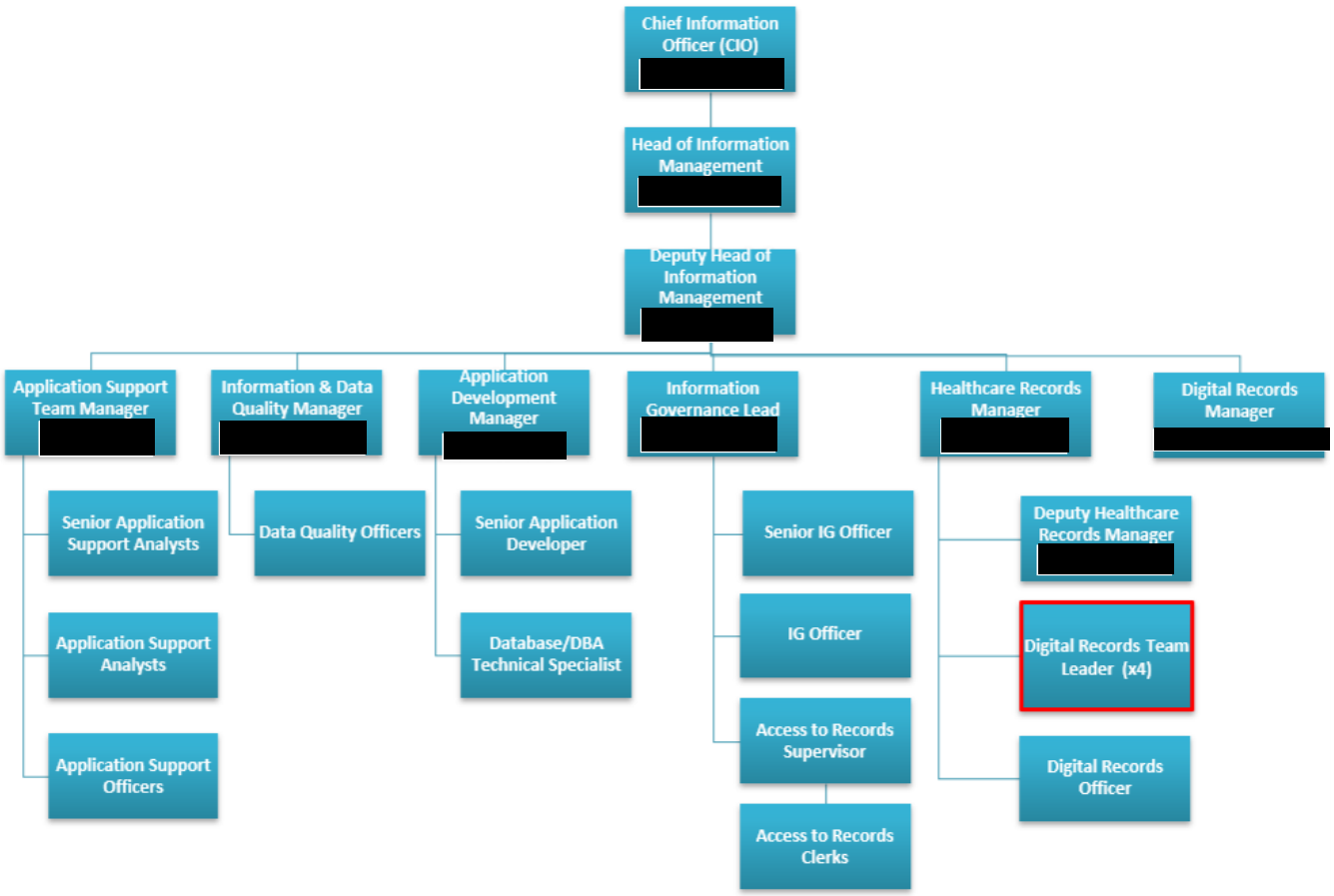
The post holder is required to deal effectively with staff of all levels throughout the Trust as and when they encounter on a day to day basis.

In addition, the post holder will deal with the wider healthcare community and external organisations. This will include verbal, written and electronic media.

Of particular importance are working relationships with:

• Healthcare Records Management Team	• GP's
• Health Records staff	• Patients
• Information Governance Manager	
• Senior Digital Services Managers and staff	
• Clinicians	
• Admin and Clerical staff across the Trust	

ORGANISATIONAL CHART



FREEDOM TO ACT

The post holder should be capable of working under their own cognisance, and recognising when they need support from a manager. They will be expected to work within the structure of policies and procedures.

COMMUNICATION/RELATIONSHIP SKILLS

The post holder will assist the department manager in the training and induction of new members of staff to the department. They will assist with staff appraisals and ensure mandatory training is up to date, be involved with staff development and the smooth running of the department.

The post holder will be the first line of support for providing advice, instruction and training for staff including communication of work procedures and changes.

ANALYTICAL/JUDGEMENTAL SKILLS

Judgements involving facts or situations, some requiring analysis.
Will provide advice and guidance to staff on issues and actions for preparation, scanning, quality assurance and destruction of notes

Will provide advice and guidance to staff on disclosure of information in accordance with current legislation.

PLANNING/ORGANISATIONAL SKILLS

The post holder will plan allocation of workload to their team, work with other supervisors and deputy manager in the rostering of staff and manage the basic prioritising of workload for self and others.

PATIENT/CLIENT CARE

The post holder is not required to have any formal contact with patients. Any contact will be incidental in their movement through the hospital

POLICY/SERVICE DEVELOPMENT

The post holder will be required to implement policies and propose changes to practices and procedures for own area. They will be expected to participate in proposing changes to working practices and procedures when appropriate; and implement new procedures when these are agreed.

FINANCIAL/PHYSICAL RESOURCES

The post holder will be required to ensure the safe use of equipment other than equipment used personally and will be responsible for ensuring any required office supplies are available.

HUMAN RESOURCES

The post holder will be responsible for the day to day management, allocation and checking of their teams work activities, and will provide core training in their specialist area.

They will assist department managers in staff 1:1's, appraisal, initial stages of grievance and discipline matters, and assist with recruitment.

INFORMATION RESOURCES

The post holder will be responsible for ensuring that the processing and storage of patient data in the two electronic systems is done accurately and in line with policies and procedures.

RESEARCH AND DEVELOPMENT

The post holder will undertake surveys or audits as required within own work environment e.g. to test effectiveness of procedures

PHYSICAL SKILLS

Physical skills obtained through practice/Developed physical skills; advanced keyboard use.

The postholder will be able to use their touch-typing skills to accurately and quickly transpose patient information, including patient identifier and clinical information from paper to systems. The postholder will be able to properly format information as it is being entered.

PHYSICAL EFFORT

Frequent light effort for several short periods; with occasional moderate effort for several short periods.

Combination of sitting, standing and walking dealing with telephone enquiries; inputting at keyboard for most of the day; some lifting, sorting, filing, general handling of case records; Pushing trolleys with patient notes, retrieving records

MENTAL EFFORT

Concentration while preparing documentation; dealing with frequent interruptions and competing demands from staff or work-related queries.

EMOTIONAL EFFORT

Occasional distressing or emotional circumstances – dealing with initial stages of: -

- staff absence management;
- disciplinary issues;
- performance management
- staff grievances/complaints

WORKING CONDITIONS

The post holder will not be required to work in adverse environmental conditions.

There is a requirement to work with paper records, stored on appropriate racking, and therefore a requirement to use appropriate equipment for access. The post holder is required to contribute to a safe working environment, comply with health and safety guidelines and ensure a personal duty of care at all times.

OTHER RESPONSIBILITIES

Take part in regular performance appraisal.

Undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling

Contribute to and work within a safe working environment

You are expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

You must also take responsibility for your workplace health and wellbeing:

- When required, gain support from Occupational Health, Human Resources or other sources.
- Familiarise yourself with the health and wellbeing support available from policies and/or Occupational Health.
- Follow the Trust's health and wellbeing vision of healthy body, healthy mind, healthy you.
- Undertake a Display Screen Equipment assessment (DES) if appropriate to role.

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Everyone within the Trust has a responsibility for, and is committed to, safeguarding and promoting the welfare of vulnerable adults, children and young people and for ensuring that they are protected from harm, ensuring that the Trusts Child Protection and Safeguarding Adult policies and procedures are promoted and adhered to by all members of staff.

Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust continue to develop our long-standing partnership with a view to becoming a single integrated organisation across Eastern and Northern Devon. Working together gives us the opportunity to offer unique and varied careers across our services combining the RD&E's track record of excellence in research, teaching and links to the university with NDHT's innovation and adaptability.

PERSON SPECIFICATION

Job Title	Digital Records Supervisor

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING	(NVQ 4 level of knowledge and competence gained through the qualifications and vocational skills/experience set out in the sections below) A-Levels/NVQ Level 3 or diploma in relevant subject or equivalent Minimum GCSE or equivalent in English and Mathematics ECDL or equivalent	
KNOWLEDGE/SKILLS	Knowledge of Health Records and Administrative processes across the Trust Knowledge of Information Governance processes Ability to develop and maintain effective working relationships Demonstrable leadership skills Knowledge of case note structure and content Knowledge of the patient journey and patient case note procedure High level of computer literacy Good keyboard skills	
EXPERIENCE	Proven experience of supervising others Proven clerical experience Demonstrable experience of working to strict deadlines Experience of working within data protection and confidentiality requirements Experience of managing own work load	Experience of using an electronic document management system Experience of using an electronic patient record system
PERSONAL ATTRIBUTES	Excellent organisations skills, and ability to prioritise own workload	

	Excellent interpersonal / communication skills Good understanding of working within a team A flexible approach to work and working relationships Ability to remain calm and professional in a busy environment	
OTHER REQUIREMENTS	The post holder must demonstrate a positive commitment to uphold diversity and equality policies approved by the Trust Ability to travel to other locations as required	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	Y		X		
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	N				
Electrical work	N				
Physical Effort	Y		X		
Mental Effort	Y				X
Emotional Effort	Y		X		
Working in isolation	Y	X			
Challenging behaviour	Y	X			

NHS
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JOB DESCRIPTION

JOB DETAILS	
Job Title	Digital Records Officer
Reports to	Deputy Manager Healthcare Records
Band	Band 3
Department/Directorate	Healthcare Records / Digital Services

JOB PURPOSE

The introduction of CITO, an electronic documentation management (EDM) system for Healthcare Records is a core component of the fully integrated Electronic Patient Record that the Trust envisages. When implemented, along with Epic, an electronic patient record, the current healthcare records will be transformed into an electronic form through a digitisation process that will capture an electronic image of all pages in a health record, no matter what type.

The purpose of this role is to support the digitisation of the paper record is carried out correctly and in line with our statutory obligations. Aspects of the role will include the preparation of records for scanning into either electronic system, scanning of records accurately within either electronic system, undertaking quality assurance of scanned records and participating in the identification and preparation of notes for destruction.

The Trust will have two separate locations for this role, and the post holder will be required to work flexibly in both locations and within the four principle tasks within the department.

KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The Digital Records Officer will have the following key duties and responsibilities:

- To carry out the timely retrieval of remaining paper generated within agreed clinical areas across Trust sites
- To undertake the careful preparation of paper-based health records material to ensure that it is in good order and is suitable for electronic scanning
- To scan prepared documentation to the appropriate electronic system accurately, ensuring that the documentation is scanned to the correct record and electronically filed in the appropriate location
- To undertake the required quality assurance activity to ensure that all scanning, including that carried out outside the department has been carried out in accordance with policies and procedures and meets our statutory obligations
- To undertake the identification and preparation of paper notes for destruction in accordance with policies and procedures, ensuring we meet our statutory obligations
- To record and properly maintain document information in the appropriate application to enable the audit process to be completed accurately
- To ensure that any errors or discrepancies identified as part of the quality assurance checks undertaken are flagged for the attention of the supervisor or manager at the soonest possible opportunity so these can be checked, verified and remedial action taken.

- To ensure if duplicate electronic medical records are identified in either Epic or CITO that this is flagged for the attention of the supervisor or manager at the soonest possible opportunity so these can be checked, verified and remedial action taken

- To ensure that the security and confidentiality of patient's information is maintained at all times as per the Trust's confidentiality and Security of Patient Information Policy.

KEY WORKING RELATIONSHIPS

Areas of Responsibility:
Preparation of notes for scanning, accurate scanning of clinical information, conduct Quality Assurance of scanned notes, undertake preparation of notes for destruction

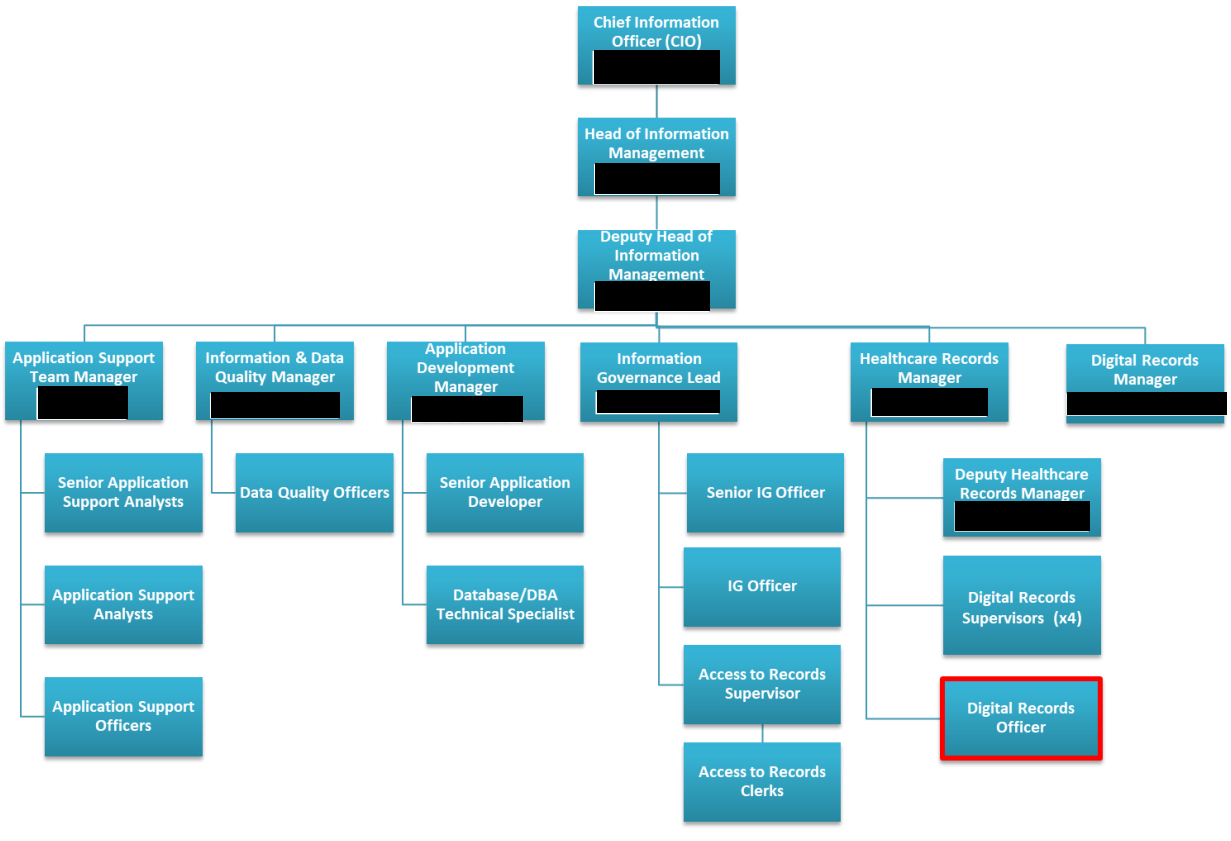
No. of Staff reporting to this role: N/A

The post holder is required to deal effectively with staff of all levels throughout the Trust as and when they encounter on a day to day basis. This will include verbal, written and electronic media.

Of particular importance are working relationships with:

Internal to the Trust	External to the Trust
• Healthcare Records Management Team • Health Records staff • Information Governance Manager • Senior Digital Services Managers and staff • Clinicians • Admin and Clerical staff across the Trust	• GP's • Patients • • • •

ORGANISATIONAL CHART



FREEDOM TO ACT

The post holder is required to respond to enquiries, work with advice and guidance from line manager and work within the structures of standard operating procedures, policies and guidelines

COMMUNICATION/RELATIONSHIP SKILLS

The post holder will provide and receive routine information requiring tact and persuasive skills. Examples of these skills involve challenging and persuading senior clinical staff on their actions with regards to clinical document governance.
They will communicate complex work procedures within their own team and with other departments, and be involved in the induction and training of new staff

ANALYTICAL/JUDGEMENTAL SKILLS

The post holder will be required to be able to make judgements on a range of facts that require analysis and comparison of a range of options. These will involve decisions that have an impact on data quality, compliance with GDPR and the accurate availability of clinical documentation.

PLANNING/ORGANISATIONAL SKILLS

The post holder will be required to organise their own day to day activities, with some planning of ongoing straightforward activities, these will involve organisation of collection rotas etc.

The post holder will be able to recognise and deal with changing priorities in order to meet the services requirements and changing deadlines

PATIENT/CLIENT CARE

The post holder is not required to have any formal contact with patients. Any contact will be incidental in their movement through the hospital

POLICY/SERVICE DEVELOPMENT

Implement policies and propose changes to practices, procedures for own area.

The post holder will be expected to continue to contribute to process change being developed in the department. Contribution is provided through team meetings and process review meetings.

The post holder will be involved in the implementation of scanning and record management policy developed in the department to wider areas of the Trust.

FINANCIAL/PHYSICAL RESOURCES

The post holder has no financial responsibility within the service.

The post holder has a responsibility to treat physical resources responsibly and in line with manufacturers guidelines and Digital Services policies and procedures.

HUMAN RESOURCES

The post holder is to actively contribute to the smooth running of the service by ensuring harmonious working relationships with all colleagues.

The post holder should be able to assist in the training and induction of new members of staff to the department

INFORMATION RESOURCES

The post holder will be process and store patient data in the two electronic systems accurately and in line with policies and procedures.

RESEARCH AND DEVELOPMENT

There is no research and development responsibility for this role

PHYSICAL SKILLS

Physical skills obtained through practice/Developed physical skills; advanced keyboard use.

The postholder will be able to use their touch-typing skills to accurately and quickly transpose patient information, including patient identifier and clinical information from paper to systems. The postholder will be able to properly format information as it is being entered.

PHYSICAL EFFORT

Frequent light effort for several short periods; with occasional moderate effort for several short periods.

Combination of sitting, standing and walking dealing with telephone enquiries; inputting at keyboard for most of the day; some lifting, sorting, filing, general handling of case records; Pushing trolleys with patient notes, retrieving records

MENTAL EFFORT

Concentration while preparing documentation; dealing with frequent interruptions and competing demands from staff or work-related queries.

EMOTIONAL EFFORT

The post holder may encounter frequent indirect exposure to distressing or emotional circumstances when having to assess clinical documentation to provide accurate document storage when scanning. Examples will include assessing sensitive clinical information which gives photographic or written description of distressing clinical, physical and emotional detail.

WORKING CONDITIONS

Exposure to unpleasant working conditions is rare.

There is a requirement to work with paper records, stored on appropriate racking, and therefore a requirement to use appropriate equipment for access. Some archive storage areas are dusty, and are not ideal working environments.

The post holder is required to contribute to a safe working environment, comply with health and safety guidelines and ensure a personal duty of care at all times.

OTHER RESPONSIBILITIES

Take part in regular performance appraisal.

Undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling

Contribute to and work within a safe working environment

You are expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

You must also take responsibility for your workplace health and wellbeing:

- When required, gain support from Occupational Health, Human Resources or other sources.
- Familiarise yourself with the health and wellbeing support available from policies and/or Occupational Health.
- Follow the Trust's health and wellbeing vision of healthy body, healthy mind, healthy you.
- Undertake a Display Screen Equipment assessment (DES) if appropriate to role.

GENERAL

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PERSON SPECIFICATION

Job Title	Digital Records Officer

Requirements	Essential	Desirable
QUALIFICATION / SPECIAL TRAINING	(NVQ 3 level of knowledge and competence gained through the qualifications and vocational skills/experience set out in the sections below) or equivalent experience Minimum GCSE or equivalent qualification in English and Mathematics	
KNOWLEDGE/SKILLS	Knowledge of Health Records and Administrative processes across the Trust High level of computer literacy	Knowledge of case note structure and content
EXPERIENCE	Proven clerical experience or working within a similar role Demonstrable experience of working to strict deadlines	Experience of using an electronic document management system Experience of using an electronic patient record system Experience of working within data protection and confidentiality requirements
PERSONAL ATTRIBUTES	Proven experience of adaptability in the workplace, with a flexible approach to work Excellent interpersonal/communication skills Proven experience of working effectively within a team Demonstrable ability to develop and maintain effective working relationships Demonstrable ability to plan and organise your own workload Ability to remain calm and professional in a busy environment	
OTHER REQUIREMENTS	The post holder must demonstrate a positive commitment to uphold	

	diversity and equality policies approved by the Trust Ability to travel to other locations as required	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	Y		O		
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	N				
Electrical work	N				
Physical Effort	Y			X	
Mental Effort	Y			X	
Emotional Effort	Y	X			
Working in isolation	Y	X			
Challenging behaviour	Y	X			

Royal Devon and Exeter NHS
NHS Foundation Trust

JOB DESCRIPTION

1. JOB DETAILS

Job Title: **Administrative Services Manager**

Band: **6**

Responsible To: **Head of Records Management**

Accountable To: **Head of Records Management**

Department/Division: **IMT**

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director

2. JOB PURPOSE

The Administrative Services Manager will assist the Head of Records Management in the management and co-ordination of a responsive and customer focused Health Records service. They are accountable for the operational management and on-going development of administrative services to support and meet the on-going needs of the clinical services. They will manage casenote storage requirements and advise the Head of Records Manager of issues and suggest solutions. They will deputise for the Head of Records Management in periods of absence.

They will further support the Trust through the development and implementation of specific projects with reference to service and strategic needs of both the Division and the Trust. Specifically the post holder will:

- Ensure that the administrative service is appropriately resourced and the work is closely aligned to the needs of individual service lines with reference to the broader Trust's strategic agenda and direction
- Ensure that administrative services function effectively on a day to day basis, supporting the needs of Service Lines
- Support and motivate the administrative workforce to focus on the needs and experience of the service user and ultimately of patients
- Engender a learning and supportive environment where best practice is shared across the whole organisation and adopted as standard operating practice.
- Promote a culture of continuous improvement and share this knowledge across the trust to improve efficiencies, increase patient care and drive down costs
- Ensure implementation and continual compliance with relevant Standard Operating Procedures (SOPs)
- Assist in creating appropriate, robust and sustainable structures Trust-wide to ensure the effective line management and support of administrative staff

- Provide support to Head of Records Management
- Ensure all information is secure and confidentiality of information is maintained at all times
- Provide excellent customer care which may include communication with clinicians and senior managers, using influencing and negotiation skills
- Ensure the professional image of the Trust is maintained at all times

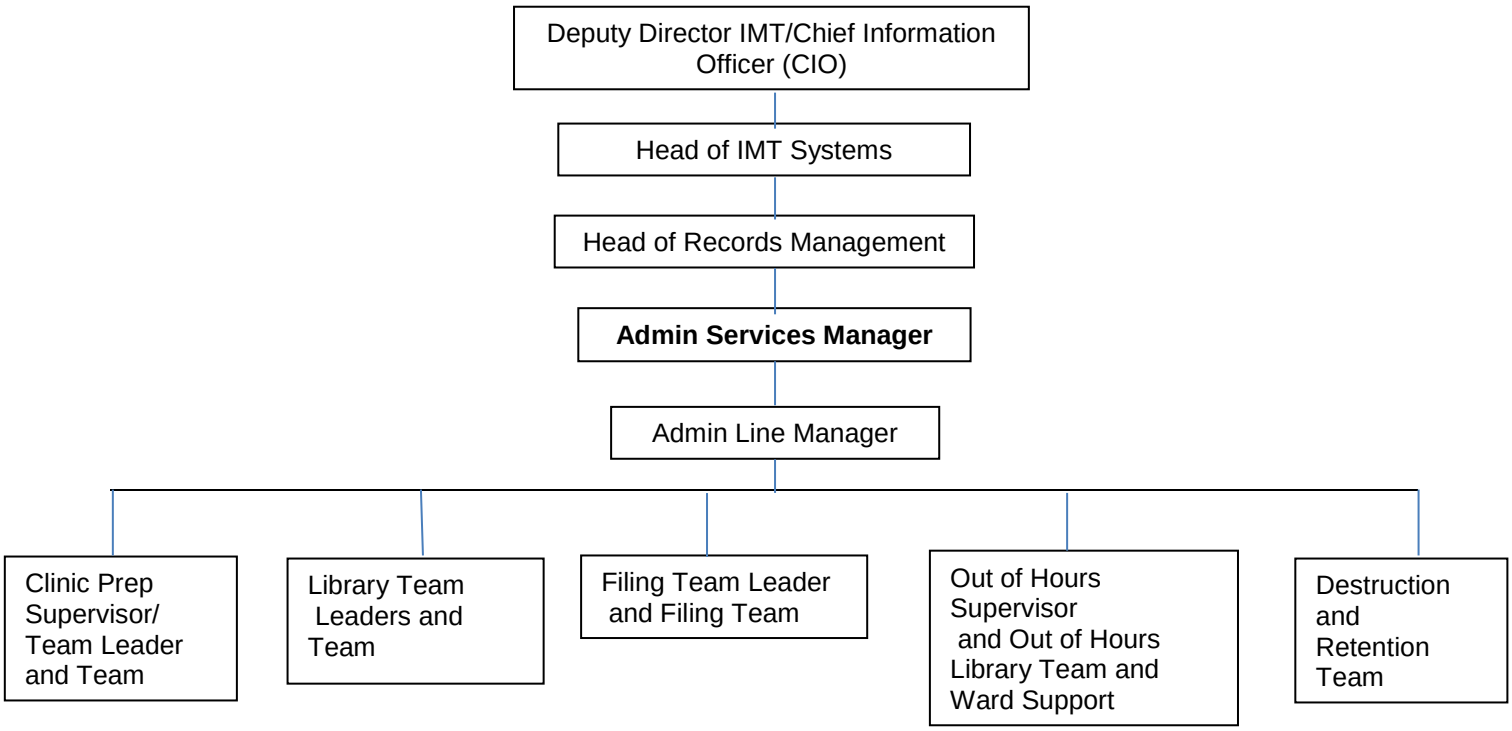
3. KEY WORKING RELATIONS

Internal to the Trust	External to the Trust
Head of Records Management IM&T Senior Managers Administrative Services Managers/Administrative Line Managers Cluster Managers Consultants and other members of the medical team Patients and their relatives GPs Divisional Management team Senior Nursing staff and other ward staff Other members of the multi-professional clinical team Health Records Staff Administration and secretarial teams across the Trust Central Support Team Management accountants	Equipment Suppliers User Groups Contract suppliers, eg Transport, storage, cleaning

4. DIMENSIONS

- 75.79 wte staff
- The post holder will be responsible for the overall administrative services function within the Health Records Department which operates a 24 hour service, 7 days a week including bank holidays.
- This post may involve some evening/weekend/bank holiday working on an ad hoc basis.
- The post holder will be part of a Trust Administration team.

5. ORGANISATIONAL CHART



6. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES:

Supervisory and Human Resources

- Personal accountability for the overall operational management of administrative services
- Leadership of administrative staff to foster a positive, supportive culture conducive to the effective delivery of administrative services
- Development and maintenance of robust and effective line management arrangements for the administrative workforce
- To coach and mentor Administrative Line Manager(s) in all aspects of performance management including sickness, conduct and capability management
- Support to administration line managers in resolving complex or contentious issues including performance management of staff through to final disciplinary/capability hearings and the performance management of staff with protected characteristics
- To drive down percentage of sickness absence, performance and capability costs and cases within administrative and clerical teams
- Responsibility for robust and effective recruitment and retention of administrative staff to meet the needs of the Health Records Service
- To provide an effective link between administrative staff and senior Trust management, cascading information as appropriate and briefing the Head of Records Management on relevant issues.
- Direct line management of administrative staff
- Effective liaison and co-operation with ASMs in other areas to ensure administrative services across the Trust are consistently aligned
- Ensuring that administrative services and their management are aligned to all relevant Trust policies including HR, health and safety and all relevant employment legislation
- Creation, development and control of performance reports relating to administrative services

- Support the day to day management of agreed policies and protocols in relation to patient access
- Ensure that day to day access issues can be resolved in an effective and timely manner
- Ensure that performance related information is accurate, relevant and validated as appropriate
- Support the Health Records Service to meet all relevant performance indicators
- Ensure that all PDRs (appraisals), return to work (sickness) interviews, mandatory (essential) training are completed by all administrative and clerical staff within the Trust's defined timelines, and that this information is accurately recorded on the Trust's system (ESR) in a timely manner

Administrative functions

- Use multiple computer systems as required within the department such as PAS, NHS e-referrals, ESR
- Ensure accurate and up-to-date patient details are maintained on patient information systems such as PAS, in line with Trust Information Governance policy
- Maintain health records and patient files in line with Trust Health Records Policy
- Support the Head of Records Management in ensuring that complaints/incidents are dealt with promptly and effectively and where appropriate, escalate if unable to resolve
- Execution of action plans in response to complaints/incidents related to Health Records administrative services

Service delivery/improvement

- On-going review and development of the administrative service to best meet the needs of patients with reference to the trust's strategic direction
- Lead on administrative change across diverse systems and multiple specialties
- Work closely with the Head of Records Management to support the move to an electronic patient record and the change in working practices within the Health Records Department
- Monitor all Health Records storage areas regarding capacity and growth and escalate issues to the Head of Records Management with recommendations and options
- Plan and execute changes in service and impact on the Health Records Department
- Plan and execute of service development projects with complex issues and multiple interdependencies
- Anticipate potential issues arising from service development and taking appropriate action to mitigate them
- Devise new ways of working, including the initiation and development of Standard Operating Procedures
- Deliver Health Records training, eg casenote training, review training regularly, update and develop relevant training in co-ordination with the Head of Records Management
- Support effective workforce planning to ensure the Trust has an administrative workforce aligned to its strategic objectives
- Accountable for the development and delivery of specific projects as required by the Trust
- Effective engagement with stakeholders during the development and implementation of specific projects
- Coordination of complaint responses related to administrative services, including meeting senior clinicians/managers as and when required
- Development and execution of action plans in response to complaints/incidents.
- Coordination of investigations into incidents related to administrative issues and the development of action plans arising from those investigations
- Ensure that appropriate risk assessments are undertaken and acted upon for administrative services within the Division
- Deputise for the Head of Records Management during periods of absence.
- Maintain an up to date knowledge of HR policies and their impact on staff

- Contribute to the NHS service improvement/modernisation agenda e.g. service redesign
- Lead on developing processes within the department to meet the demands of a growing service
- Participate in team and Trust meetings as required, eg Records Management Group
- Contribute to audits regarding departmental procedures
- Have a flexible approach to working hours to meet the demands of the service
- Adhere to the Trust Health Records Policy and appropriate standard operating procedures, Service SLAs, Key Performance Indicators, government targets and standard operational policies

Communication

- Make and receive telephone calls both external and internal according to Trust standards
- Communicate effectively including discussion and written communication
- Proactively manage email communication in line with the RD&E's Email Best Practice guidance
- Provide excellent customer care, in a calm and professional manner – some situations may be challenging
- Organise and/or support team meetings through effective communication
- Contribute to meetings and groups in a professional and positive manner

Governance

- Undertake training as required to maintain competency/comply with trust policies
- Work within Trust policies – including those for confidentiality, data protection, health and safety fire protection, and annual appraisal
- Adhere to the Trust Access Policy, Health Records Policy and Key Performance Indicators, government targets and standard operational policies and procedures

Resource/Finance Management

- Ensure the effective management of resources within the established budget
- Continuous delivery of value for money and Cost Improvement Program as required by the Trust
- Ensure robust mechanisms for the timely and cost effective procurement of equipment and consumables for administrative services
- Provide cover in periods of absence as directed by the Head of Records Management, this may involve moving to other areas
- Monitor use of supplies and stationery and ensure this is done efficiently and cost effectively in line with the needs of the service

Additional Responsibilities

- The post holder will be expected to carry out any other duties as required, commensurate with their pay band
- The post holder will be required to facilitate and support new starters to carry out their role
- The post holder will understand the limitations of the role and how to access support
- The post holder will understand the limitations of the role and escalate issues as appropriate to the Head of Records Management

Trustwide Responsibilities

- To take part in regular performance appraisal
- To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling
- To contribute to and work within a safe working environment

- The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/her at all times in such a manner as to minimise the risk of healthcare associated infection.

THE TRUST – Vision and Values

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

Honesty, Openness & Integrity
Fairness,
Inclusion & Collaboration
Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

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The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call: 01392 207462.

Royal Devon and Exeter NHS
NHS Foundation Trust

PERSON SPECIFICATION
POST: Administrative Services Manager
BAND: 6

REQUIREMENTS	**Essential / Desirable at:**	
	Recruitment	**1st PDR or (award of) increment**
QUALIFICATIONS / TRAINING:		
Educated to 'A' level standard or equivalent	**E**	**E**
Minimum of 3 qualifications to include GCSE grade A-C/4-9 or equivalent in Maths and English	**E**	**E**
NVQ 3 in Business Admin or equivalent	**E**	**E**
ILM Level 3 in Team Leading	**E**	**E**
Clinical Document Management (CDM)	**D**	**E**
Patient Administration System (PAS) Level 4 outpatients	**E**	**E**
ECDL, CLAIT or equivalent	**D**	**E**
AMSPAR Medical Terminology or equivalent	**D**	**E**
Postgrad. Management qualification or equivalent professional experience	**E**	**E**
Risk Assessor qualification	**D**	**E**
KNOWLEDGE / SKILLS:		
Excellent planning & organisational skills	**E**	**E**
Ability to prioritise workload to respond to changing demand	**E**	**E**
Ability to liaise and communicate with staff at all levels	**E**	**E**
Motivation and negotiation skills	**E**	**E**
Excellent interpersonal & communication skills inc. demonstrating empathy & sensitivity to patients and relatives	**E**	**E**
Ability to promote good working liaisons (staff, patients, relatives)	**E**	**E**
Extracting information / Listening Skills	**E**	**E**
Knowledge of Health Records processes	**E**	**E**
Ability to handle complex enquiries	**E**	**E**
Ability to deal with challenging behaviour	**E**	**E**
Ability to provide excellent customer care	**E**	**E**
Knowledge of IT databases and computer systems	**E**	**E**
Comprehensive PC skills - databases, word-processing, email, Excel	**E**	**E**
Understanding of hospital IT systems	**E**	**E**
Knowledge of PAS or equivalent information system	**E**	**E**
Analytical skills & ability to problem solve	**E**	**E**
Proven strong administration skills	**E**	**E**
Accurate data entry	**E**	**E**
Excellent telephone manner	**E**	**E**
Knowledge of Trust procedures	**E**	**E**
Able to work independently, with minimum supervision	**E**	**E**
Proven ability to motivate staff and encourage team work	**E**	**E**
Ability to coach and mentor others	**E**	**E**
Ability to effectively supervise staff on a day to day basis	**E**	**E**
Ability to effectively performance manage staff	**E**	**E**
Ability to engage and influence staff within their area of responsibility	**E**	**E**
Knowledge of PDR process	**E**	**E**
Practical knowledge of change management	**D**	**E**
Ability to deal with members of a multi-disciplinary team	**E**	**E**
Ability to co-ordinate complex diary management	**E**	**E**
Good decision making skills	**E**	**E**

Thorough understanding of NHS performance targets	**E**	**E**
Basic understanding of the compliance framework for NHS Foundation Trusts	**E**	**E**
Understanding of the basics of finance and health and safety	**D**	**E**
Understanding of the principles of audit	**D**	**E**
Knowledge of patient flow	**E**	**E**
Knowledge of Trust procedures	**E**	**E**
EXPERIENCE:		
Previous clerical experience	**E**	**E**
Working in an NHS/clinical environment e.g. hospital, GP surgery, CCG	**E**	**E**
Management of staff and the development of staff	**E**	**E**
Operational managing of a service on a day to day basis	**E**	**E**
Managing Administrative functions within a large complex organisation	**E**	**E**
Formal performance management of staff	**E**	**E**
Managing sickness absence and conduction of performance or capability investigations	**E**	**E**
Staff rostering	**E**	**E**
Implementing change in a discrete area	**E**	**E**
Managing a change process	**E**	**E**
Holding budgetary responsibility	**D**	**E**
PERSONAL ATTRIBUTES:		
Enthusiastic highly motivated & committed to delivering a service	**E**	**E**
Understand team work and work within a team	**E**	**E**
Able to plan and organise workload	**E**	**E**
Able to prioritise own work load and meet deadlines	**E**	**E**
Ability to work un-supervised	**E**	**E**
Can remain calm and professional in a busy environment	**E**	**E**
Empathetic, but able to understand professional boundaries	**E**	**E**
Smart appearance, adhering to the Uniform Policy	**E**	**E**
Welcoming friendly and approachable manner	**E**	**E**
An adaptable approach to work	**E**	**E**
Flexible approach to working hours	**E**	**E**
Commitment to continual development to inc. relevant new systems, policies and procedures	**E**	**E**
Adheres to relevant Trust policies & procedures	**E**	**E**
Adheres to confidentiality & data protection requirements	**E**	**E**

Hazards within the role, used by Occupational Health for risk assessment					
Laboratory specimens		Clinical contact with patients		Dealing with violence & aggression of patients/relatives	
Blood / Body Fluids		Dusty environment		VDU Use	✓
Radiation / Lasers		Challenging behaviour	✓	Manual Handling	✓
Solvents		Driving		Noise / Vibration	
Respiratory sensitisers		Food Handling		Working in isolation	
Cytotoxic drugs		Electrical work		Night working	

Royal Devon and Exeter NHS
NHS Foundation Trust

JOB DESCRIPTION

This post has been identified as involving access to vulnerable adults and/or children and in line with Trust policy successful applicants will be required to undertake an Enhanced Disclosure Check.

The Trust is committed to recruiting and supporting a diverse workforce and so we welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. The Trust expects all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

1. JOB DETAILS

Job Title: Health Records Supervisor

Band: Band 4

Reports to: Head of Records Management

Department / Directorate: Health Records Department/IMT

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director

2. JOB PURPOSE

To ensure the Health Records Department is fully staffed and supported on a day to day basis ensuring the provision of a responsive and customer focused service to the Trust and outside agencies. To provide specialist knowledge on health records functions/services.

To provide support to the ASM Health Records.

To supervise the day to day management of the Health Records department in conjunction with the ASM.

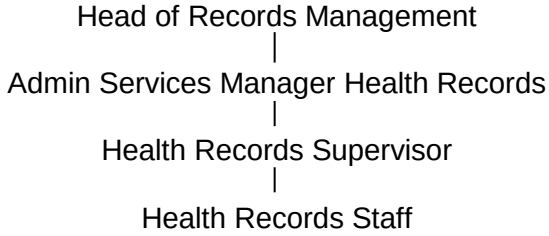
NB. It is key that this postholder works closely with the ASM, Health Records to ensure that all the Health Records sections (library, clinic prep, filers, out of hours, ward support, Bell House) work corporately across the Trust to provide maximum service quality and efficiency, this may involve staff working across areas if service dictates.

3. DIMENSIONS/ KEY WORKING RELATIONS

To supervise approx 74 WTE staff

Head of Records Management
ASM, Health Records
ALM, Health Records
IM&T Senior staff
Directorate and other Service Managers
Consultant Medical Staff
Senior Outpatient Nurse and Nursing Staff
ASMs/ALMs
Choose and Book Staff
Administration and secretarial teams across the Trust
Health Records staff across the Trust

4. ORGANISATIONAL CHART:



5. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES:

People

- In conjunction with the ASM/ALM, supervise the Health Records staff across all sections of the Dept on a day-to-day basis
- To ensure the Department is adequately staffed at all times, arranging bank cover within the established budget and the Working Time Directive Guidance utilising the availability of the Peripatetic Staff for planned and unplanned staff absence in conjunction with the ASM.
- To maintain accurate and up to date records of annual and sick leave. To proactively participate in the informal sickness monitoring of all staff.
- To liaise with staff regarding sickness absence and fill in a Return to Work form and pass to the Admin Services Manager
- To ensure all staff undertake their duties in accordance with the Trust's relevant Health Records Policies and Procedures
- To ensure all staff conform with Health & Safety regulations at all times to include the immediate reporting of mobile racking faults, kick stools etc
- To ensure all staff undergo the Trust mandatory training (manual handling and health and safety) on appointment and receive annual refresher training and to maintain accurate records of attendance.
- To provide specialist on the job Health Records training to staff to ensure staff are providing an efficient and effective service.

- To undertake performance, planning and reviews of staff in conjunction with the ASM, ensuring that accurate records are kept and ESR is updated timely.
- In conjunction with the ASM ensure new staff receive a Corporate and Departmental induction and the appropriate training to undertake their job.
- To hold regular meetings with Health Records staff ensuring that accurate and concise minutes are taken and forwarded to the ASM.
- To deal with any informal performance issues, with guidance and support from the ASM and Human Resources.
- To assist in the recruitment and selection of staff, including short listing.

Special Delivery

- To ensure all work is carried out within the agree timescales, ie urgent requests for casenotes to A & E, prepping of notes to clinic, routine pulling requests etc. To notify the ASM immediately if timescales cannot be achieved.
- To review current processes and use specialist knowledge to assist in ensuring that the service evolves to met the changing needs of new initiatives and delivers patient care in a timely manner.
- To maximise efficiency of staff and where appropriate develop new ways of working either utilising technology or undertaking other tasks within the Health Records Dept.
- To monitor, audit, review and where required improve the standard of service provide by the Dept.
- To monitor and review storage requirements and maximise current storage usage
- To ensure that multi-volume casenotes are split in accordance with the Trust policies and procedures and to provide training on such as requested.
- To ensure confidentiality is maintained throughout the Dept and staff are aware of their responsibilities under the terms of the Data Protection Act and Information Governance Policy.
- To participate in the Misfile Procedure.
- Ensure all Health Records areas are kept clean and tidy and undertake regular risk assessments to ensure compliance with Health and Safety requirements.
- To undertake manual handling training for Health Records staff.
- To ensure that all accidents and incidents are recorded accurately.
- To ensure all accidents/incidents are reported timely to the ASM Health Records and ensure that appropriate action is taken to avoid recurrence.
- Hours of duty may be flexible as part of rota system with other Health Records Supervisors
- To undertake any other duties commensurate with the grade as required by the ASM Health Records and Head of Records Management.

Other Responsibilities:

To take part in regular performance appraisal

To undertake any training required in order to maintain competency including mandatory training, i.e. Fire, Manual Handling

To contribute to and work within a safe working environment

The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

THE TRUST - PURPOSE AND VALUES

We are committed to serving our community by being a high quality specialist Hospital with consultant-led services. We aim to co-ordinate our services with primary and community care, and to develop a limited number as Sub-Regional Referral Centres with appropriate levels of research, development and

educational involvement. Where appropriate, and consistent with our services, we may provide services aimed at preventing disease and debilitation.

We aim to make all our services exemplary in both clinical and operational aspects. We will show leadership in identifying healthcare needs to which we can respond and in determining the most cost-effective way of doing so. We will share our knowledge with neighbouring healthcare agencies and professionals.

We recruit competent staff whom we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

The Trust is committed to recruiting and supporting a diverse workforce and so we welcome applications from all sections of the community, regardless of age, disability, sex, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status The Trust expects all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, the Trust reserves the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call 01392 207462.

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/her at all times in such a manner as to minimise the risk of healthcare associated infection.

Royal Devon and Exeter NHS
NHS Foundation Trust

PERSON SPECIFICATION

POST: HEALTH RECORDS SUPERVISOR
BAND: 4

REQUIREMENTS	At Recruitment	At 2nd KSF Gateway
QUALIFICATIONS / TRAINING		
Specialist knowledge acquired through professional qualification or equivalent experience in a Health Records setting.	E	E
IHRIM Diploma/Certificate or equivalent experience	E	E
ILM Management/Supervisory Certificate	E	E
NNQIII Administration/Customer Service or equivalent experience	E	E
Medical terminology an advantage	D	E
H & S Risk Assessor Certificate	D	E
H & S Manual Handling Training Certificate	D	E
KNOWLEDGE / SKILLS		
Communicates complex health records specialist queries with own, other departments or external agencies and has the training ability to develop own and other dept staff as required.	E	E
Operational knowledge of Trust and Health Records Policies and Procedures	E	E
Excellent customer care and service provision skills	E	E
Excellent understanding of acute and primary care – patient journey	E	E
Excellent keyboard skills and ability to use WP, database/ spreadsheet packages	E	E
Numerate	E	E
Ability to negotiate with NHS and external organisations regarding service issues	E	E
EXPERIENCE		
Experience of supervising others – good leadership skills	E	E
Experience of being able to prioritise workload	E	E
Experience of working under pressure to meet tight deadlines	E	E
Experience of managing and implementing change	D	E
Ability to work on own initiative and make decisions	E	E
Operational health records experience across a range of roles	E	E
Understanding of the Recruitment and Selection process	E	E
Self motivated and ability to motivate others	E	E
Understanding of Data Protection Act an advantage	D	E

PERSONAL ATTRIBUTES		
Flexible approach	E	E
Exceptional organisation skills	E	E
Professional approach	E	E
Highest Integrity	E	E
Ability to work as part of a team including implementing and improving processes	E	E
Excellent interpersonal and communication (both verbal and written) skills	E	E
Ability to remain calm when under pressure	E	E
Enthusiastic, committed to professionally develop staff	E	E
OTHER REQUIREMENTS		
Current valid driving licence	E	E
Good attendance record	E	E

* Essential/Desirable

HAZARDS IDENTIFIED (*tick as appropriate)*:					
Laboratory specimens Proteinacious Dusts		Clinical contact with patients		Performing Exposure Prone Invasive Procedures	
Blood / Body Fluids		Dusty environment	X	VDU use	X
Radiation		Challenging Behaviour		Manual handling	X
Solvents		Driving	X	Noise	
Respiratory Sensitisers		Food handling		Working in isolation	

Royal Devon and Exeter NHS
NHS Foundation Trust

JOB DESCRIPTION

1. JOB DETAILS

Job Title: Administration Assistant

Band: Band 2

Reports to: Administration Line Manager

Accountable to: Administration Services Manager

Department / Directorate: Health Records/IM&T

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director

2. JOB PURPOSE

- Provide a professional, efficient, accurate and responsive administrative support function
- Undertake general clerical duties
- To work on your own or as part of a team carrying out deliveries of goods as required and as per schedule, to accurately complete all driving records as per current legislation.
- To carry out a range of duties associated with the movement of casenotes, within Health Records storage areas and hospital buildings, together with fast and accurate sorting, in order to support quality patient care. To contribute to the safe transporting of cages, trolleys and boxes within this busy environment.
- The holder will work in a defined team within Health Records (Clinic Prep or Library) but may be required to work across the Department in order to provide an effective and timely service
- Provide excellent customer care
- To communicate effectively with a multidisciplinary team using initiative, tact and diplomacy.
- To manage and prioritise workload on a daily basis meeting changing demands.
- Ensure all information is secure and confidentiality of information is maintained at all times
- Ensure the professional image of the Trust is maintained at all times

3. KEY WORKING RELATIONS

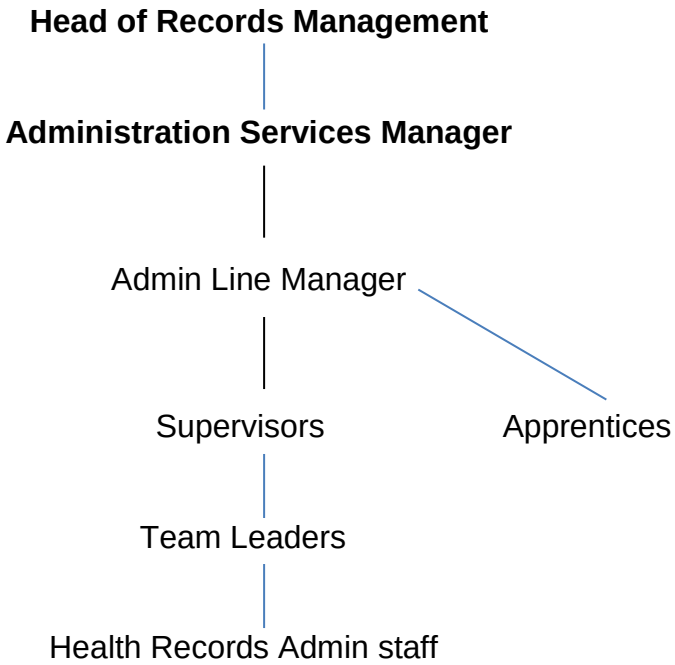
- Head of Records Management
- Administrative Services Manager/Administrative Line Manager
- Consultants and other members of the medical team

- GPs
- Divisional Management team
- Senior Nursing staff and other ward staff
- Other members of the multi-professional clinical team
- Health Records & IM&T Departments
- Administration and secretarial teams across the Trust
- Central Support Team

4. DIMENSIONS:

- The post holder will be responsible for undertaking clerical duties to support the process of the Trust's patient activity and to meet the relevant departmental targets.
- There will be a requirement for the post holder to deliver goods as per schedules to Royal Devon and Exeter NHS Foundation Trust sites and other customers across the region, carry out vehicle checks as required and complete all relevant documentation.
- The post holder when working in the Library Team will be expected to work between all Health Records storage areas on and off site
- The Health Records Department is a 24/7 service employing approximately 100 staff

5. ORGANISATIONAL CHART



6. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES:

Administrative functions

- To provide and receive routine information regarding patients attending Outpatient and Inpatient attendance's.
- Provide advice and information to staff, external agencies and a range of healthcare professionals using initiative, tact and persuasive skills.

- Staff will be required to have a working knowledge of the Patient Administration System, gained through intensive training.
- Experience and knowledge of the patient journey is acquired through job training. This is essential in requesting and obtaining patient case notes timely and effectively.
- To manage, organise and prioritise own workload on a daily basis, ensuring that the clinic workload for the week ahead is planned, prepared and organised to meet the deadlines of the service. Work pattern can be unpredictable and requires good concentration level and the ability to multi task.
- To be able to recognise and deal with changing priorities in order to meet tight deadlines
- To promptly locate, retrieve and tracer case notes and subsequently deliver/dispatch for Emergency Admissions.
- To provide routine and urgent case notes in a responsive and timely manner to the Trust and other hospitals. This will involve retrieving the case notes from current, secondary or off site storage by driving a Trust vehicle.
- To be responsible for ensuring that all case notes for patients attending out-patient clinics and emergency admissions are available in time for the consultation, and that all case notes are prepared in accordance with the relevant RD&E Trust Health Records Policies and Procedures, and Consultant's wishes.
- To ensure that a full and extensive search is carried out across the RD&E and other hospitals for all 'missing' case notes in order that they are prepared and traced in time for the consultation. This will involve investigating and tracking of case notes and the disclosure of patient information in accordance with the Data Protection Act and the Trusts Confidentiality Policy. If case notes are not available, this may result in the patient's Outpatient appointment being cancelled.
- To ensure that all referral letters are available, where required, in time for the consultation. Collect referral letter daily from each Outpatient area and file inside of the patient's case notes. Contact the patients GP if a referral letter is missing and request a faxed copy.
- To ensure that case notes of all additions to the clinic lists are retrieved, prepared and traced on PAS in time for the consultation and in accordance with the RD&E Trust Policies and Procedures. This will involve changing workload priorities in order to meet service needs. Deliver case notes to the Outpatient area.
- To ensure the movement of case notes is input onto the PAS system and to ensure that up to date identification labels are printed and put in the case notes.
- The fast and accurate sorting, tracing and filing of patient casenotes, returned to the Health Records Department for filing. This may involve filing in Bell House.
- Moving/Filing patients casenotes between/in current and non-current filing areas.
- The regular supervision and maintenance of working areas by moving (shuffling) the casenotes around the filing shelves in order to keep the records evenly spaced and easily accessible.
- To minimise the creation of temporary folder by undertaking regular comprehensive misfile searches, and to ensure that these searches are documented.
- To file paper data within the case notes in accordance with the Trusts Order of Filing Policy.
- To ensure that any temporary folders are amalgamated with the original case notes and the Tracer record updated accordingly.
- To ensure that all case notes are in good and tidy order, and to replace case note folders where necessary.
- To participate in the efficient collection of case notes from departments as required, using the appropriate equipment.
- When requested by the Clinic Preparation Team Leader, assist colleagues with their workload, ensuring that each respective job plan is adhered to.
- To ensure that the work area is kept clean and tidy at all times.

Service delivery and improvement

-
- To ensure that there is an adequate supply of relevant stationery and stock, in order to carry out duties effectively

- Contribute to team/department audits regarding department procedures/performance
- To actively contribute to the smooth running of the service by ensuring harmonious working relationships with all colleagues
- Participate in team meetings as required
- Contribute to the NHS service improvement/modernisation agenda eg service redesign
- Work as part of a team in developing processes within the department to meet the demands of a growing service
- Have a flexible approach to working hours to meet the demands of the service
- Adhere to the Trust Access Policy and Health Records Policy and appropriate standard operating procedures, Key Performance Indicators, government targets and standard operational policies

Driving Role

- To drive vehicles safely and responsibly at all times
- To ensure daily vehicle checks are carried out thoroughly and defects are reported as per departmental procedures
- To observe strictly the departmental regulations regarding use of vehicles
- To carry out deliveries/collections as per schedules and times.
- To keep vehicles clean inside and out
- To comply with speed limits as posted
- To report promptly any accidents/incidents to Transport Manager/Transport Admin Manager completing appropriate forms
- To advise anything affecting driving licences regarding convictions for motor offences or health problems
- To load, unload, push and pull cages and trolleys containing boxes of casenotes
- To ensure that the security and confidentiality of patient's casenotes and information is maintained at all times as per the Trust policies
- To comply with the Trust's Health and Safety Regulations. To attend all required yearly mandatory training
- To report promptly, prior to the commencement of the shift, any illness/injury which may make driving hazardous
- To undertake other such duties commensurate with the grading of this post as required by the Transport Manager/ASM Health Records
- To undertake any training required in order to maintain competency including mandatory training, i.e. Fire, Manual Handling

Communication

- To communicate effectively with anxious staff, healthcare professionals and clinicians in stressful situations
- To ensure that emergency telephone request from authorised sources are dealt with politely and courteously and actioned in a timely and friendly manner
- Disclose patient information to appropriate clinical staff in accordance with current relevant legislation.
- To actively contribute to the smooth running of the service by ensuring harmonious working relationships with all colleagues
- Provide excellent customer care, in a calm and professional manner – some situations may be challenging
- Communicate effectively including discussion and written communication

Governance

- Undertake training as required to maintain competency/comply with trust policies
- Work within Trust policies – including those for confidentiality, data protection, health and safety fire protection, and annual appraisal

- Adhere to the Trust Health Records Policy to ensure that the security and confidentiality of patient's case notes
- Adhere to the Trust Access Policy, Key Performance Indicators, government targets and standard operational policies and procedures
- To contribute to a safe working environment, by reporting any broken/damaged equipment immediately to the ASM/ALM. Ensuring a personal duty of care

Resource Management

- Provide cover in periods of absence as directed by department manager, this may involve moving to other areas
- Monitor use of supplies and stationery and ensure this is done efficiently and cost effectively in line with the needs of the service

Additional Responsibilities

- The post holder will be expected to carry out any other duties as required, commensurate with their pay band
- The post holder will be required to facilitate and support new starters to carry out their role
- The post holder will understand the limitations of the role and how to access support
- The post holder will cover the Health Records Reception Desk when necessary. This will involve dealing with queries from other departments, liaising with other Trust staff, including Clerical staff, Healthcare Professions and Clinicians

Trust wide Responsibilities

- To take part in regular performance appraisal
- To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling
- To contribute to and work within a safe working environment
- The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/her at all times in such a manner as to minimise the risk of healthcare associated infection.

THE TRUST – Vision and Values

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

Honesty, Openness & Integrity
Fairness,
Inclusion & Collaboration
Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

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Royal Devon and Exeter NHS
NHS Foundation Trust

PERSON SPECIFICATION

POST: Administration Assistant
BAND: 2

REQUIREMENTS	At Recruitment	1st PDR or award increment
QUALIFICATIONS / TRAINING		
Good general education "O" level/GCSE A-C in English Language and Maths.	E	E
NVQ Level 2 in Administration/Customer Service or equivalent experience	E	E
KNOWLEDGE / SKILLS		
Excellent planning and organisational skills	E	E
Ability to prioritise workload to respond to changing demand	E	E
Ability to liaise and communicate with staff at all levels	E	E
Ability to work without supervision	D	E
Ability to deal with challenging behaviour	D	E
Ability to provide excellent customer care	E	E
Comprehensive PC skills – databases, word-processing, email, Excel	D	E
Knowledge of filing systems	E	E
Knowledge of Patient Administration System (PAS)	D	E
Knowledge of the patient journey and patient case note procedures	D	E
Analytical skills and ability to problem solve	D	E
Accurate data entry	E	E
EXPERIENCE		
Proven clerical/administration experience	E	E
Working in a busy acute environment	D	E
Proven team worker	E	E
Of managing own workload and working to strict deadlines	E	E
Experience of using PAS	D	E
PERSONAL ATTRIBUTES		
Enthusiastic highly motivated and committed to delivering a service	E	E
Positive team worker with the ability to promote good working liaisons	E	E
Good interpersonal skills	E	E
Can remain calm and professional	E	E
Ability to work accurately too tight deadlines	E	E
Commitment to detail / Ability to concentrate	E	E
Ability to use own initiative	E	E

An adaptable approach to work Flexible approach to working hours Organised Highest Integrity Smart Appearance – adhering to Uniform Policy Commitment to continual development to include relevant new systems, policies and procedures. Adheres to Trust policies and procedures	E E E E E E E	E E E E E E E
OTHER REQUIREMENTS Ability to lift and carry weights of up to 15kgs Ability to walk distances Current – valid (manual) driving license	 E E E	 E E E

* Essential/Desirable

HAZARDS IDENTIFIED (*tick as appropriate)*:					
Laboratory specimens Proteinacious Dusts		Clinical contact with patients		Performing Exposure Prone Invasive Procedures	
Blood / Body Fluids		Dusty environment	X	VDU use	X
Radiation		Challenging Behaviour		Manual handling	X
Solvents		Driving	X	Noise	
Respiratory Sensitisers		Food handling		Working in isolation	

Royal Devon and Exeter NHS
NHS Foundation Trust

JOB DESCRIPTION

1. JOB DETAILS

Job Title: Administration Assistant

Band: Band 2

Reports to: Administration Line Manager

Accountable to: Administration Services Manager

Department / Directorate: Health Records/IM&T

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director

2. JOB PURPOSE

- Provide a professional, efficient, accurate and responsive administrative support function
- Undertake general clerical duties
- To work on your own or as part of a team carrying out deliveries of goods as required and as per schedule, to accurately complete all driving records as per current legislation.
- To carry out a range of duties associated with the movement of casenotes, within Health Records storage areas and hospital buildings, together with fast and accurate sorting, in order to support quality patient care. To contribute to the safe transporting of cages, trolleys and boxes within this busy environment.
- The holder will work in a defined team within Health Records (Clinic Prep or Library) but may be required to work across the Department in order to provide an effective and timely service
- Provide excellent customer care
- To communicate effectively with a multidisciplinary team using initiative, tact and diplomacy.
- To manage and prioritise workload on a daily basis meeting changing demands.
- Ensure all information is secure and confidentiality of information is maintained at all times
- Ensure the professional image of the Trust is maintained at all times

3. KEY WORKING RELATIONS

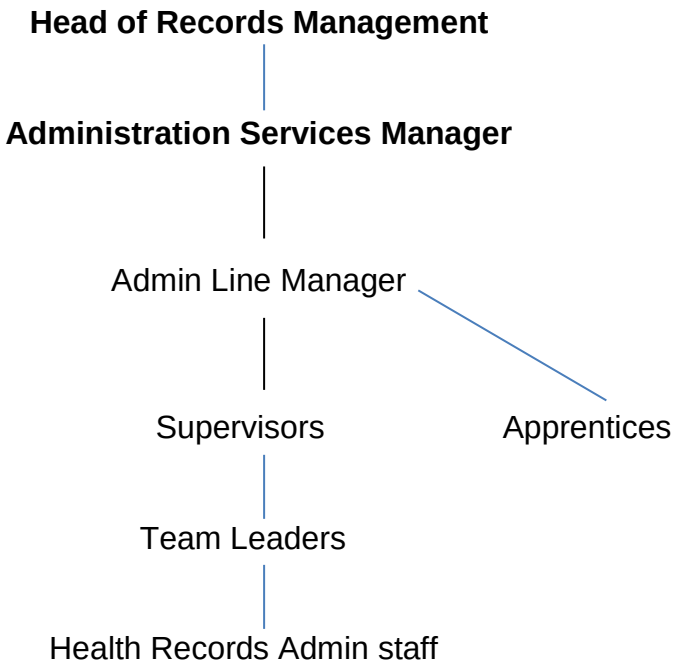
- Head of Records Management
- Administrative Services Manager/Administrative Line Manager
- Consultants and other members of the medical team
- GPs
- Divisional Management team
- Senior Nursing staff and other ward staff

- Other members of the multi-professional clinical team
- Health Records & IM&T Departments
- Administration and secretarial teams across the Trust
- Central Support Team

4. DIMENSIONS:

- The post holder will be responsible for undertaking clerical duties to support the process of the Trust's patient activity and to meet the relevant departmental targets.
- There will be a requirement for the post holder to deliver goods as per schedules to Royal Devon and Exeter NHS Foundation Trust sites and other customers across the region, carry out vehicle checks as required and complete all relevant documentation.
- The post holder when working in the Library Team will be expected to work between all Health Records storage areas on and off site
- The Health Records Department is a 24/7 service employing approximately 100 staff

5. ORGANISATIONAL CHART



6. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES:

<u>Administrative functions</u>

- To provide and receive routine information regarding patients attending Outpatient and Inpatient attendance's.
- Provide advice and information to staff, external agencies and a range of healthcare professionals using initiative, tact and persuasive skills.
- Staff will be required to have a working knowledge of the Patient Administration System, gained through intensive training.

- Experience and knowledge of the patient journey is acquired through job training. This is essential in requesting and obtaining patient case notes timely and effectively.
- To manage, organise and prioritise own workload on a daily basis, ensuring that the clinic workload for the week ahead is planned, prepared and organised to meet the deadlines of the service. Work pattern can be unpredictable and requires good concentration level and the ability to multi task.
- To be able to recognise and deal with changing priorities in order to meet tight deadlines
- To promptly locate, retrieve and tracer case notes and subsequently deliver/dispatch for Emergency Admissions.
- To provide routine and urgent case notes in a responsive and timely manner to the Trust and other hospitals. This will involve retrieving the case notes from current, secondary or off site storage by driving a Trust vehicle.
- To be responsible for ensuring that all case notes for patients attending out-patient clinics and emergency admissions are available in time for the consultation, and that all case notes are prepared in accordance with the relevant RD&E Trust Health Records Policies and Procedures, and Consultant's wishes.
- To ensure that a full and extensive search is carried out across the RD&E and other hospitals for all 'missing' case notes in order that they are prepared and traced in time for the consultation. This will involve investigating and tracking of case notes and the disclosure of patient information in accordance with the Data Protection Act and the Trusts Confidentiality Policy. If case notes are not available, this may result in the patient's Outpatient appointment being cancelled.
- To ensure that all referral letters are available, where required, in time for the consultation. Collect referral letter daily from each Outpatient area and file inside of the patient's case notes. Contact the patients GP if a referral letter is missing and request a faxed copy.
- To ensure that case notes of all additions to the clinic lists are retrieved, prepared and traced on PAS in time for the consultation and in accordance with the RD&E Trust Policies and Procedures. This will involve changing workload priorities in order to meet service needs. Deliver case notes to the Outpatient area.
- To ensure the movement of case notes is input onto the PAS system and to ensure that up to date identification labels are printed and put in the case notes.
- The fast and accurate sorting, tracing and filing of patient casenotes, returned to the Health Records Department for filing. This may involve filing in Bell House.
- Moving/Filing patients casenotes between/in current and non-current filing areas.
- The regular supervision and maintenance of working areas by moving (shuffling) the casenotes around the filing shelves in order to keep the records evenly spaced and easily accessible.
- To minimise the creation of temporary folder by undertaking regular comprehensive misfile searches, and to ensure that these searches are documented.
- To file paper data within the case notes in accordance with the Trusts Order of Filing Policy.
- To ensure that any temporary folders are amalgamated with the original case notes and the Tracer record updated accordingly.
- To ensure that all case notes are in good and tidy order, and to replace case note folders where necessary.
- To participate in the efficient collection of case notes from departments as required, using the appropriate equipment.
- When requested by the Clinic Preparation Team Leader, assist colleagues with their workload, ensuring that each respective job plan is adhered to.
- To ensure that the work area is kept clean and tidy at all times.

Service delivery and improvement

-
- To ensure that there is an adequate supply of relevant stationery and stock, in order to carry out duties effectively
- Contribute to team/department audits regarding department procedures/performance

- To actively contribute to the smooth running of the service by ensuring harmonious working relationships with all colleagues
- Participate in team meetings as required
- Contribute to the NHS service improvement/modernisation agenda eg service redesign
- Work as part of a team in developing processes within the department to meet the demands of a growing service
- Have a flexible approach to working hours to meet the demands of the service
- Adhere to the Trust Access Policy and Health Records Policy and appropriate standard operating procedures, Key Performance Indicators, government targets and standard operational policies

Driving Role

- To drive vehicles safely and responsibly at all times
- To ensure daily vehicle checks are carried out thoroughly and defects are reported as per departmental procedures
- To observe strictly the departmental regulations regarding use of vehicles
- To carry out deliveries/collections as per schedules and times.
- To keep vehicles clean inside and out
- To comply with speed limits as posted
- To report promptly any accidents/incidents to Transport Manager/Transport Admin Manager completing appropriate forms
- To advise anything affecting driving licences regarding convictions for motor offences or health problems
- To load, unload, push and pull cages and trolleys containing boxes of casenotes
- To ensure that the security and confidentiality of patient's casenotes and information is maintained at all times as per the Trust policies
- To comply with the Trust's Health and Safety Regulations. To attend all required yearly mandatory training
- To report promptly, prior to the commencement of the shift, any illness/injury which may make driving hazardous
- To undertake other such duties commensurate with the grading of this post as required by the Transport Manager/ASM Health Records
- To undertake any training required in order to maintain competency including mandatory training, i.e. Fire, Manual Handling

Communication

- To communicate effectively with anxious staff, healthcare professionals and clinicians in stressful situations
- To ensure that emergency telephone request from authorised sources are dealt with politely and courteously and actioned in a timely and friendly manner
- Disclose patient information to appropriate clinical staff in accordance with current relevant legislation.
- To actively contribute to the smooth running of the service by ensuring harmonious working relationships with all colleagues
- Provide excellent customer care, in a calm and professional manner – some situations may be challenging
- Communicate effectively including discussion and written communication

Governance

- Undertake training as required to maintain competency/comply with trust policies
- Work within Trust policies – including those for confidentiality, data protection, health and safety fire protection, and annual appraisal

- Adhere to the Trust Health Records Policy to ensure that the security and confidentiality of patient's case notes
- Adhere to the Trust Access Policy, Key Performance Indicators, government targets and standard operational policies and procedures
- To contribute to a safe working environment, by reporting any broken/damaged equipment immediately to the ASM/ALM. Ensuring a personal duty of care

Resource Management

- Provide cover in periods of absence as directed by department manager, this may involve moving to other areas
- Monitor use of supplies and stationery and ensure this is done efficiently and cost effectively in line with the needs of the service

Additional Responsibilities

- The post holder will be expected to carry out any other duties as required, commensurate with their pay band
- The post holder will be required to facilitate and support new starters to carry out their role
- The post holder will understand the limitations of the role and how to access support
- The post holder will cover the Health Records Reception Desk when necessary. This will involve dealing with queries from other departments, liaising with other Trust staff, including Clerical staff, Healthcare Professions and Clinicians

Trust wide Responsibilities

- To take part in regular performance appraisal
- To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling
- To contribute to and work within a safe working environment
- The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/her at all times in such a manner as to minimise the risk of healthcare associated infection.

THE TRUST – Vision and Values

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

Honesty, Openness & Integrity
Fairness,
Inclusion & Collaboration
Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call: 01392 207462.

Royal Devon and Exeter NHS
NHS Foundation Trust

PERSON SPECIFICATION

POST: Administration Assistant
BAND: 2

REQUIREMENTS	At Recruitment	1st PDR or award increment
QUALIFICATIONS / TRAINING		
Good general education "O" level/GCSE A-C in English Language and Maths.	E	E
NVQ Level 2 in Administration/Customer Service or equivalent experience	E	E
KNOWLEDGE / SKILLS		
Excellent planning and organisational skills	E	E
Ability to prioritise workload to respond to changing demand	E	E
Ability to liaise and communicate with staff at all levels	E	E
Ability to work without supervision	D	E
Ability to deal with challenging behaviour	D	E
Ability to provide excellent customer care	E	E
Comprehensive PC skills – databases, word-processing, email, Excel	D	E
Knowledge of filing systems	E	E
Knowledge of Patient Administration System (PAS)	D	E
Knowledge of the patient journey and patient case note procedures	D	E
Analytical skills and ability to problem solve	D	E
Accurate data entry	E	E
EXPERIENCE		
Proven clerical/administration experience	E	E
Working in a busy acute environment	D	E
Proven team worker	E	E
Of managing own workload and working to strict deadlines	E	E
Experience of using PAS	D	E
PERSONAL ATTRIBUTES		
Enthusiastic highly motivated and committed to delivering a service	E	E
Positive team worker with the ability to promote good working liaisons	E	E
Good interpersonal skills	E	E
Can remain calm and professional	E	E
Ability to work accurately too tight deadlines	E	E
Commitment to detail / Ability to concentrate	E	E
Ability to use own initiative	E	E
An adaptable approach to work	E	E
Flexible approach to working hours	E	E

Organised Highest Integrity Smart Appearance – adhering to Uniform Policy Commitment to continual development to include relevant new systems, policies and procedures. Adheres to Trust policies and procedures	E E E E E	E E E E E
OTHER REQUIREMENTS Ability to lift and carry weights of up to 15kgs Ability to walk distances Current – valid (manual) driving license	 E E E	 E E E

* Essential/Desirable

HAZARDS IDENTIFIED (*tick as appropriate)*:					
Laboratory specimens Proteinacious Dusts		Clinical contact with patients		Performing Exposure Prone Invasive Procedures	
Blood / Body Fluids		Dusty environment	X	VDU use	X
Radiation		Challenging Behaviour		Manual handling	X
Solvents		Driving	X	Noise	
Respiratory Sensitisers		Food handling		Working in isolation	

JOB DESCRIPTION

Royal Devon and Exeter NHS Foundation Trust

"Our vision is to provide safe, high quality seamless service delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust Values"

JOB DETAILS	
Job Title	Programme Manager
Reports to	Deputy Chief Information Officer
Band	8a
National Job Profile used	Programme Manager
Department/Directorate	Digital Services Division

JOB PURPOSE

The Digital Services Division aims to develop a culture of continual service improvement. The post holder will be an advocate for this culture across the service area and demonstrate continual service improvement in the services for which they are responsible.

The Digital Services Division Programme Managers will report to the Deputy Chief Information Officer and provide expert programme and project management for a portfolio of projects within the overall Digital Services Division and its Strategy.

The post-holder will lead on complex programmes and projects and be accountable for the planning, structuring and execution of such programmes / projects. The post-holder will provide task management, mentoring and training for project teams and will be responsible for projects producing results capable of achieving benefits as defined within the Business Cases and Project Initiation Documents.

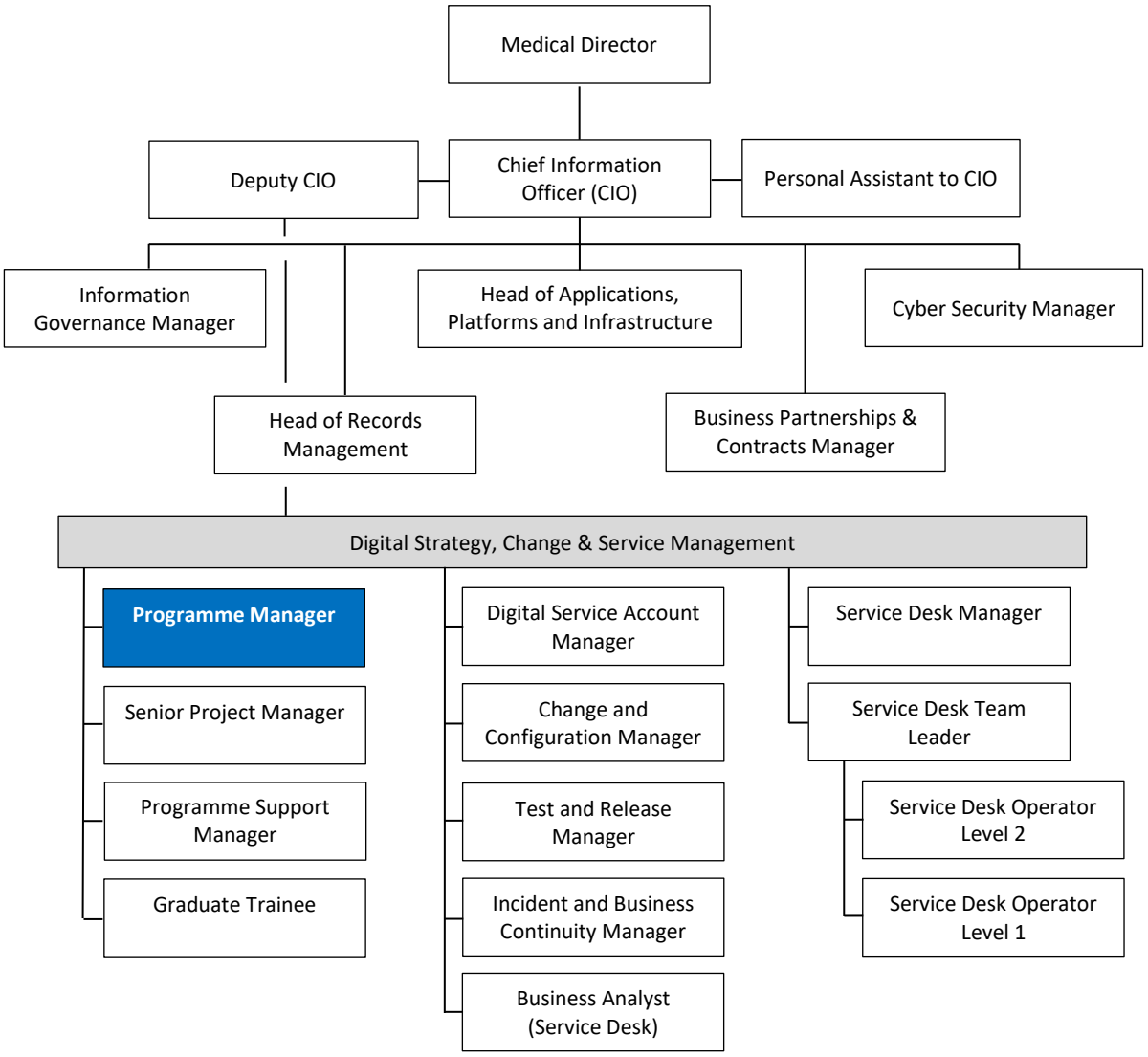
The post-holder will be responsible for the management of multidisciplinary teams, ensuring appropriate financial and human resources are made available to programmes and projects. The post-holder will provide a responsive and customer focused service to constituent organisations within an SLA framework and will make a significant contribution to service development within the NHS through the successful delivery of Digital Services Division projects and the re-engineering of business processes.

The post holder will not only provide a programme/project management service but be a support to Digital Services Division Business As Usual teams as required.

KEY WORKING RELATIONSHIPS	
Internal to the Trust	**External to the Trust**
Divisional Directors	External Clients and Partners
Trust Service Managers	Epic technical experts and implementation team
Information Asset Owners	3rd Party Service and Solution Providers
Digital Services Division	NHS Digital and NHSX
Finance Department	

Procurement Department Internal Committees and Governance meetings Trust User Base	NHS England and NHS Improvement Colleagues in other NHS and Social Care organisations

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The key result areas for the role are described in the following sections:

COMMUNICATION/RELATIONSHIP SKILLS

- Provide and receive highly complex, sensitive and contentious information;
- Present complex, sensitive or contentious information/presentations to large groups;
- To persuade senior/executive management boards and senior management of the importance of the initiative/programme;
- To negotiate with staff and motivate on project delivery, including linking in with other initiatives.

ANALYTICAL/JUDGEMENTAL SKILLS

- To interpret, analyse and compare ranges of complex facts or options;
- To make decisions on a range of complex project issues where there may be more than one course of action;

- To initiate appropriate action plan and gain agreement across the programme/project structure to ensure sticks to plan.

PLANNING/ORGANISATIONAL SKILLS

- Manage programme / project budgets on behalf of the Deputy Chief Information Officer;
- To set up the Programme/Project Governance and associated stakeholder management and communication plans;
- Plan and monitor the overall progress of programmes and projects;
- Day to day management responsibility for delivery of all tasks set out in the relevant programme / project plans;
- Produce business cases, options appraisals and strategic cases to secure funding and resources
- Resolve any issues and instigate corrective action as appropriate (issues management and analysis);
- Ensure the delivery of new products and/or services from projects is to the appropriate level of quality, on time and within budget, according to the programme plan;
- Risk assessment of programme and subsequent management to ensure successful completion;
- Manage third party contributions to the programmes and projects as appropriate (e.g. External Suppliers);
- Manage dependencies and interfaces between programmes and projects;
- Manage programme and project stakeholders;
- Report regularly on programme / project progress and issues to the Programme Director(s) and Chief Information Officer/Deputy Chief Information Officer;
- Ensure programme and project management skills are regularly updated personally and with multidisciplinary teams;
- Supervise and coordinate the work of project teams related to each programme and project;
- Be an escalation point for Senior Project Managers, Project Managers and Project Support Staff;
- Apply agreed Trust standards of programme and project management tools and techniques;
- Develop and manage programme / project action plans;
- Identify record, regularly review and manage programme and project risks;
- Match resources to activities and schedule building works, procurement and finance in accordance with plans;
- Authorise work and monitor progress watching for any deviations from programme / project plans and take corrective action where necessary;
- Maintain records for audit purposes and have all programme / project data available to retrieve quickly and reliably;
- Ensure each programme / project produces a result that is capable of achieving the benefits defined in the Business Case;
- Work flexibly to meet the requirements of the programme / project to ensure success including out of office hours or additional hours to meet deadlines as required. This is to accommodate working hours of other staff involved in the programme / project (**NB** The Digital Services Division Programme Manager role is demanding and whilst the contracted hours are 37.5 hours per week, some weeks may exceed this although in total over the month will average out to the contracted hours);
- To be responsible for programme and project control and any required configuration management;
- Ensure programme / project policies, procedures and standards are met and take responsibility for the quality assurance sign-off of programme / project deliverables;

- Manage programme and project risks, including the development of contingency plans;
- Agree technical and quality strategy.

PHYSICAL SKILLS

- A combination of sitting, standing and walking;
- Frequent requirement to use VDU equipment.

PATIENT/CLIENT CARE

- Ensure that the Division's services are focused on the needs of patients and clients, with the Patient at the centre of digital service delivery.

POLICY/SERVICE DEVELOPMENT

- To actively promote and secure credibility and confidence in the Digital Services Division at all levels within the constituent organisations through the delivery of a high quality, value for money customer focused service;
- Ensure Policy, Procedures and Standards are maintained at a high level to ensure quality and integrity of service delivery for programmes / projects;
- To foster good inter-directorate/multi-organisational relationships to meet their service requirements;
- To ensure that all Digital Services Division agreed programmes / projects are provided with support across all digital service delivery using Prince2, MSP and Agile methodologies;
- To provide monthly programme / project updates to the appropriate governance structures;
- To undertake ad hoc baseline programme / project initiation work as required;
- Work closely with other Digital Services Division managers to ensure delivery of the local healthcare community Digital Services Division business plan;
- Develops policies as part of the implementation of specialist programme across the Trust.

FINANCIAL/PHYSICAL RESOURCES

- Ensure that security and confidentiality is maintained at all times within the managed service;
- Ensure maximum security and integrity of data across network and take appropriate action when required;
- Monitor expenditure and costs against deliverables;
- Contribute to the development of the Digital Services Division Operational and Capital Plans and Programme Office work;
- Monitor expenditure within budget framework and programme / project timescales.

HUMAN RESOURCES

- Support and manage the development of staff within the Digital Services Division's Programme Office and other teams within the digital services as appropriate;
- To manage and mentor project staff/project teams as appropriate;
- Contributes to the development of policy and ensures implementation within the department;
- Apply a whole programme approach to individual projects;
- Facilitate multidisciplinary teams involved in the planning, implementation and benefit realisation aspects of each programme and project;
- Motivate and agree project timetables with the Deputy Chief Information Officer and relevant programme / project boards / steering groups and project teams;
- Lead the preparation and delivery of project-related stakeholder events and workshops;
- To be aware of Business As Usual workload of Digital Services Division colleagues

when setting project goals and plans to ensure buy-in;
- To support Business As Usual teams to ensure maximum effectiveness for the project;
- Promote effective working with all members of multidisciplinary teams;
- Identify and work with all appropriate staff across organisational boundaries;
- Empower and support all staff to ensure their contribution is valued;
- Develop and maintain a confident working relationship with supplier organisations;
- Develop and maintain a confident working relationship with the Trust's financial/capital account managers;
- Maintain personal, team and organisation development in Project Management practice;
- Support managers across the organisations in project administration using PRINCE methodology as a standard across all projects.

INFORMATION RESOURCES

- Oversee and manage the data and information gathering process to initiate and monitor programmes and projects including producing and regularly updating project plans;
- Produce Project Initiation Documents;
- Provide regular Checkpoint and Highlight Reports to the Programme and Project Boards and other relevant committees;
- Identify and obtain any support and advice required for the management, planning and control of programmes and projects.

RESEARCH AND DEVELOPMENT

- Undertakes research and development as required;
- Undertakes internal audits and project/programme controls compliance, such as for risk management.

FREEDOM TO ACT

- High level of professional autonomy to achieve project aims;
- Ensure that project management goals impact positively on service provision and are in alignment with local and national priorities and goals;
- Promote flexibility and adaptation in relation to working project management techniques to reflect the Trust's requirements;
- Develop operational awareness within the Division.

OTHER RESPONSIBILITIES

To take part in regular performance appraisal.

To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling.

To contribute to and work within a safe working environment.

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There will be a requirement to work evenings and weekends to meet deadlines and to

participate in a 24/7 and/or on call rota.

APPLICABLE TO MANAGERS ONLY

- Be the Subject Matter Expert for all aspects of digital services delivery for the Trust;
- All managers hold the responsibility of the health and safety and wellbeing of their staff.

THE TRUST- VISION AND VALUES

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POST	Programme Manager
BAND	8a

PERSON SPECIFICATION

Requirements	Essential	Desirable
QUALIFICATIONS/SPECIAL TRAINING :		
• Educated to masters level or equivalent professional qualification or equivalent experience	X	
• Knowledge of a range of specific project areas, acquired through post graduate diploma or equivalent experience and training	X	
• Prince2 Practitioner or equivalent experience	X	
• Managing Successful Programmes (MSP)	X	
• Agile qualification or equivalent experience		X
KNOWLEDGE/SKILLS		
• Knowledge of techniques for planning, monitoring and controlling programmes and projects	X	
• Knowledge of business change techniques such as business process re-engineering and benefits identification, modelling and management techniques	X	
• Ability to manage budgets and to plan resources according to project/organisational plans	X	
• Uses a combination of general and specialist IT knowledge and understanding to optimise the application of existing and emerging digital technology	X	
• Application of appropriate theoretical and practical methods to the analysis and solution of digital problems	X	
• Provide technical and commercial leadership	X	
• Demonstrate effective interpersonal skills	X	
• Demonstrate a personal commitment to professional standards, recognising obligations to society, professional institutions and the environment	X	
• Team management skills	X	
• Production of programme and project plans and documentation	X	
• Ability to develop and manage benefits strategy for various projects	X	
• Management skills to co-ordinate personnel from different disciplines and with differing viewpoints	X	
• High level of computer literacy	X	
• Developed analytical and problem solving skills, ability to analyse wide range of data including performance data, service redesign and identification of areas for service improvement	X	
• Ability to develop and co-ordinate departmental level customer focus strategy	X	
EXPERIENCE:		
• Knowledge of Health Service Management, including change management and workforce re-design		X
• Proven experience of managing large scale IT programmes and projects within, which attract high financial and/or business impact	X	

• Proven experience in identifying change management and implementing policies • Experience of implementing new ways of working, facilitating collaborative working across departments/staff groups • Working with staff at all levels across a multidisciplinary team • Demonstrable experience of working in multiple specialty settings • Demonstrable experience of successful negotiation with internal and external customers and suppliers • Experience of resource management specifically staff management, and budget management	X X X X X X	
PERSONAL ATTRIBUTES • Able to prioritise tasks, work on own initiative and manage own workload • Able to interpret National guidance and translate for Trust wide use • Excellent communication skills both written and verbal. Proven experience in the ability to interact with personnel at all levels both clinical and non-clinical within healthcare • Be enthusiastic, responsive to new demands, willing to learn new skills and welcome change • Motivational skills to encourage collaborative working to improve services where there may be resistance to change • Ability to plan, organise and present workshops to Trust staff • Demonstrates visionary leadership, with ability to build, nurture and inspire high performing teams • Inspires a shared purpose across diverse individuals to deliver stakeholder benefits • Leads with care, ensuring staff are treated as individuals and are able to focus on delivering an exemplary service • Open and able to evaluate information to develop proposals for improvement • Connects with colleagues to collaborate effectively and recognise different organisational structures and cultures • Shares the service vision in a clear, consistent and honest way, inspiring staff to enhanced performance • Effective engagement, promoting teamwork and a feeling of pride by valuing individuals' contributions and ideas • Holding colleagues to account by creating clarity about expectations and what success looks like in order to focus people's energy • Champions learning and capability development so that staff and others gain the skills, knowledge and experience they need to meet the future needs of the service • Influences for results, using sensitivity to plan how to reach agreement about priorities, allocation of resources or approaches to service • Able to deal effectively with unexpected situations, taking advantage of opportunities and overcome problems • Demonstrate the ability to plan and organise effectively • Excellent interpersonal skills and professional presentation • Ability to interpret national guidelines, advising colleagues	X X X X X X X X X X X X X X X X X X X X X	

accordingly, and planning change management strategies to ensure system/organisational compliance • Ability to produce and deliver, or receive and process, detailed complex and highly sensitive information	X	
OTHER REQUIRMENTS • Demonstrates ambition and clear personal career planning • Participation in Leadership Assessment Centre, 360 Degree Appraisal and Professional Registration Processes • Flexible to the requirements of the role • There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota • Requirement to travel to other sites as required • Car Driver	X X X X X X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y		X		
Food handling	N				
Night working	Y	X			
Electrical work	N				
Physical Effort	Y		X		
Mental Effort	Y				X
Emotional Effort	Y			X	
Working in isolation	Y	X			
Challenging behaviour	Y			X	

COMPETENCY REQUIREMENTS

To be completed for all new positions
Please tick which of these essential learning s is applicable to this role
(**NB** those that are mandatory for all staff with no variation on frequency are pre-populated with a tick)

Safeguarding Children	Group 1	☐	Blood Transfusion	BDS18 collection	☐	Consent Training	☐
	Group 2	☐		BDS 19 & 20 Preparing & Administering	☐	VTE Training	☐
	Group 3	☐		BDS 17 Receipting	☐	Record management and the nhs code of practice	☐
	Group 4	☐		Obtaining a blood sample for transfusion	☐	The importance of good clinical record keeping	☐
	Group 5	☐		Annual Update	☐	Antimicrobial Prudent Prescribing	☐
	Group 6	☐				Control & Restraint Annual	☐
Not mapped this one		☐	Safeguarding Adults Awareness	Clinical Staff	☐	Mental Capacity/DOL's	☐
	Group 8	☐		Non Clinical Staff	☐		
Manual Handling – Two Year		☑	Falls, slips, trips & falls	Patients	☐		
Equality & Diversity – One-Off requirement		☑		Staff/Others	☐		
Fire	Annual	☑	Investigations of incidents, complaints and claims		☐		
	Two Yearly	☐	Conflict Resolution – 3 yearly		☐		
Infection Control/Hand Hygiene	Annual requirement	☐	Waterlow		☐		
	One-Off requirement	☐	PUCLAS		☐		
Information Governance		☑	Clinical Waste Management	Application principles for clinical staff	☐		
Harassment & Bullying (Self Declaration – One off requirement)		☑		Application principles for housekeeping	☐		
				Application principles for portering and waste	☐		

JOB DESCRIPTION

Royal Devon and Exeter NHS Foundation Trust

"Our vision is to provide safe, high quality seamless service delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust Values"

JOB DETAILS	
Job Title	Senior Clinical Application Analyst
Reports to	Clinical Application Services Manager
Band	7
National Job Profile used	IM&T Analyst Advanced/Technical Engineer Specialist
Department/Directorate	Digital Services Division

JOB PURPOSE

The Digital Services Division is committed to a culture of continual service improvement. The post holder will be an advocate for this culture across their service area, contributing to and demonstrating continual service improvement in the services for which they are responsible. This role has three aspects:

1. To support management with a particular focus on helping to develop quality assurance, proactive engagement and strong resource management;
2. Be the senior system expert for a number of patient-based administrative and clinical applications; and,
3. Be responsible for the development, maintenance and support of a number of the Trust's internally developed software components, enhancements and products.

The role is based within a small team providing applications management services for a range of departmental and enterprise wide clinical information systems, the Senior Clinical Application Analyst provides cover and support for system managers of other applications and therefore requires an understanding of all systems supported by the team. The role includes:

- Responsibility for day to day management of nominated applications;
- Ongoing system optimisation to improve the efficiency and quality of the clinical systems and their associated care pathways;
- As a senior member of the Clinical Application Services Team, involvement in the management and provision of a responsive and customer focused service to all clients within a SLA framework;
- Supervision and career development of Junior Grades within the team.

The post holder will:

- Be the assigned Senior Clinical Application Analyst for some of the applications supported by the Team;
- Participate in the supervision and support of system analysts, assistants and

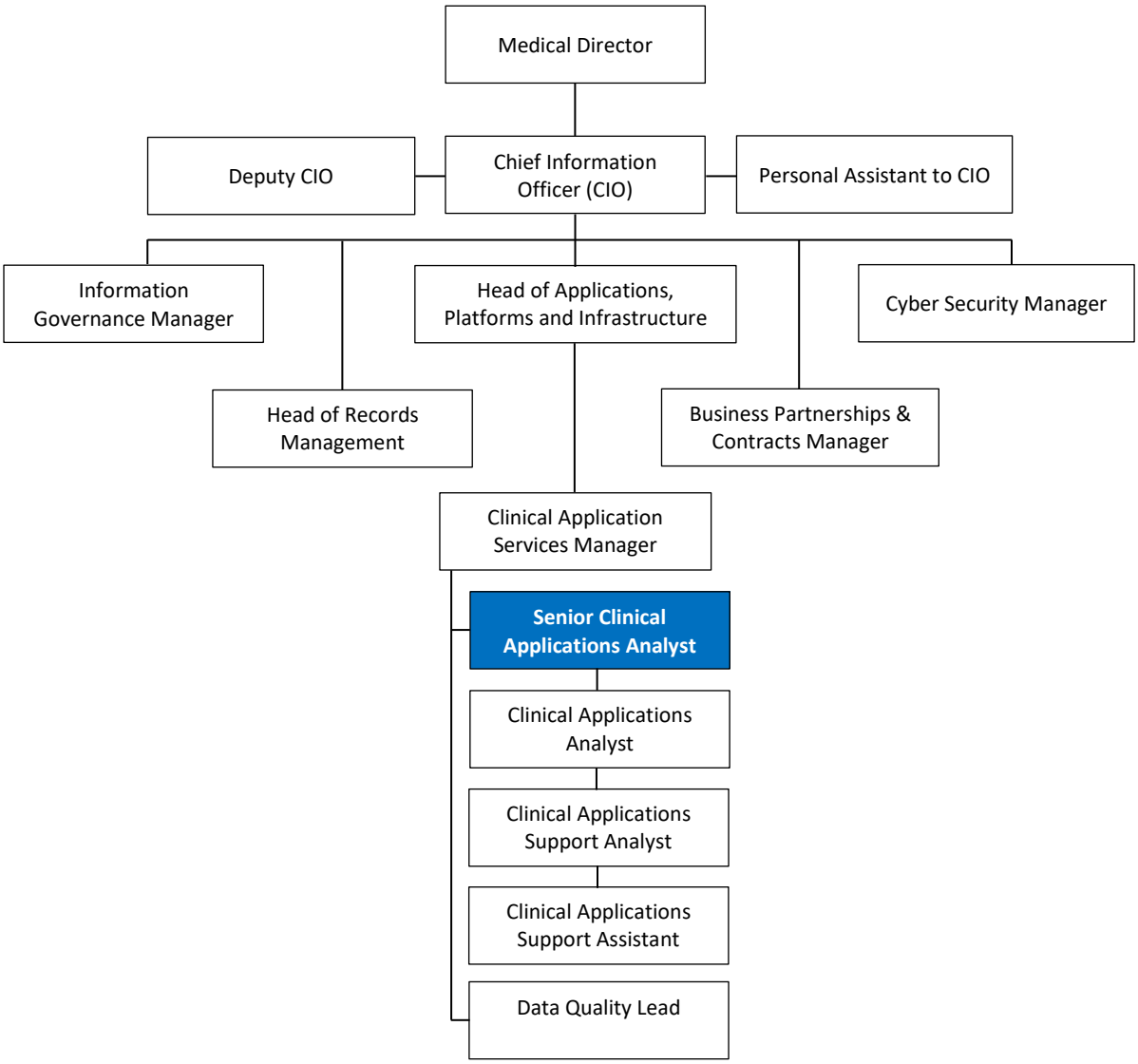
specialists within the team as required;

- Demonstrate comprehensive knowledge and expertise in system management;
- Play an active role in specifying, developing, deploying and supporting effective and secure clinical and business applications to the IMT Shared Service clients; and,
- Support a broad range of system related service development, project and workflow development tasks as required.

KEY WORKING RELATIONSHIPS

Internal to the Trust	**External to the Trust**
Divisional Directors Trust Service Managers Information Asset Owners Digital Services Division Finance Department Procurement Department Internal Committees and Governance meetings Trust User Base	External Clients and Partners Epic technical experts and implementation team 3rd Party Service and Solution Providers NHS Digital and NHSX NHS England and NHS Improvement Colleagues in other NHS and Social Care organisations

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

- Be responsible for the day to day management of a number of clinical applications;

- Manage system integrity and back office functions;
- Play a leading role in the implementation of new functionality across the Trust with specific focus on systems management and methodology;
- Ensure a standards based approach for all systems with respect to relevant Local and National policies, procedures and standards; including those for Records Management, Information Governance, Data Quality, Clinical Safety, Quality Assurance and Information Security;
- Work with developers and Suppliers to ensure system compliance with NHS Information Standards;
- Liaise with product suppliers to implement and test software systems upgrades in conjunction with Digital Services Division colleagues to assure safe system changes with minimal disruption to users;
- Manage the progress of incidents, support calls, change requests and other aspects of the service to a successful and timely conclusion and where relevant in line with the contractual Service Level Agreement;
- Ensure maintenance of system and reference files ensuring compliance with best practice, Trust and National standards;
- Monitor and report on system availability in accordance with the Trust requirement to support 24 hours a day, 7 days a week system availability for users and, in conjunction with the system suppliers and the Applications, Platforms and Infrastructure Team, be responsible for maintaining availability of the team's portfolio of applications;
- Under the supervision of the Information Asset Owner(s), to fulfil the role of Information Asset Administrator for the systems managed, and in this role, to maintain required system documentation and contribute to the maintenance of up to date system business continuity plans in conjunction with the Trust IT business continuity and disaster recovery plans, system level security policy and system information security risk assessment;
- Enable and provide a responsive service across multidisciplinary teams, resolving problems in a timely manner;
- Maintain a resolution procedure which is reflected within the Trust escalation policy;
- Ensure accurate data is recorded within the systems to support performance targets identified local and national data submissions and returns including; Referral to Treatment Time, Cancer Waiting Times, CQUINs and System Performance;
- Foster links with counterparts at other hospitals for mutual support and to share best practice in the management and use of applications;
- Co-ordinate systems testing and documentation outcomes in a test report for audit and assurance in a manner consistent with good practice and compliant with specified Trust Standards;
- Work with the Digital Training Manager to develop robust training plans and support materials for routine training, service support and introduction of new functionality or applications;
- Support the user-base and co-ordinate systems support staff in the transition between different versions of a system or migration to a new platform;
- Act and be acknowledged as the Subject Matter Expert (SME) for relevant systems within the team's remit;
- With respect to business continuity, and disaster recovery; monitor and assess the viability of existing arrangements and advise on viable options for improvement;
- Work with clinical directorates and Trust management to identify and document existing functional specifications and support the development of new functional requirements to support evolving service frameworks and drive service improvement;
- Lead the design, development and maintenance of system protocols and procedures;
- Ensure timely and accurate reporting of system and team performance.

COMMUNICATION/RELATIONSHIP SKILLS

- Present highly complex and potentially contentious information to multidisciplinary groups;
- Develop and maintain strong communications and relationships across all potential users, particularly across clinical directorates to ensure the engagement of stakeholders and the successful integration of new clinical information systems into day to day working practices;
- Engage key stakeholders throughout implementation of new functionality and maintain this relationship throughout the system lifecycle;
- For the applications within the team's portfolio; act as the system suppliers' first point of contact in the Trust for the purposes of support and system management and co-ordinate/oversee ongoing communication between Trust staff and system suppliers to ensure issues are promptly and successfully managed to resolution;
- Develop good working relationships with system suppliers and maintain effective communication to ensure high quality day to day support and that ongoing system developments and implementation are managed smoothly with minimal achievable disruption to service and to users;
- Communicate clearly with managed staff, system management team colleagues, wider Divisional colleagues and system suppliers on the functionality and design of both front end and internal system processes and the operational/business processes into which they fit;
- Ensure system maintenance and administration documentation is obtained from system suppliers and internal procedures and protocols are documented and maintained in an effective system library along with relevant system change, issue and service logs;
- With others, communicate a range of complex and sometimes controversial or sensitive issues, relating to the managed systems, to staff of all levels within the organisation in a supportive and positive manner;
- Maintain effective channels of communication across Divisions/Clusters within the Trust.

ANALYTICAL/JUDGEMENTAL SKILLS

- Act with a 'problem solving approach' in order to identify and communicate challenges within the system in a manner that facilitates successful resolution;
- Identify and interpret complex facts and scenarios to be presented to senior management and clinical staff;
- Maintain an in-depth understanding of system processes and internal configuration and how they relate to the experience of users to ensure that the system is best configured and optimised to support users in effective and efficient use of the system;
- Analyse and document new user requirements;
- Propose developed and purchased options, as appropriate and participate in selection with user.

PLANNING/ORGANISATIONAL SKILLS

- The post holder will organise their own day to day activities;
- Take a contributory role, where required, working with Divisional Programme and Projects colleagues, in the planning and management of complex system implementation and upgrades, ensuring good communication and co-ordination between internal teams and system suppliers. Adjusting plans where necessary.

PHYSICAL SKILLS

- Ability to lift and carry Information Technology (IT) equipment on occasional basis.

PATIENT/CLIENT CARE

- Patient Contact in this role is incidental.

POLICY/SERVICE DEVELOPMENT

- Contribute to enabling sustained service improvement and reducing waste in the system workflow;
- On-going review of workflow process to ensure effective use of the information technology within departments and clinical directorates;
- Identify viable options for system change with the potential to improve efficiency; realise benefit and increase resilience;
- Lead quality improvement initiatives, identifying areas where processes can be improved and in conjunction with Users and the Digital Training Manager, design new processes to be trialled evaluated and implemented.

FINANCIAL/PHYSICAL RESOURCES

- Safe use of own and others IT equipment;
- Support secure and safe operation of the incident logging system;
- Support preparation and submission of business cases for new developments that may arise from the process of delivering digital services;
- May have to assume responsibility for safe use of equipment used by others when investigating incidents.

HUMAN RESOURCES

- Undertake line management duties for Clinical Application Analysts and/or Clinical Application Support Analysts as required;
- Support the Clinical Application Services Manager to develop and implement strategic development initiatives both internal to the organisation and across organisational and sector boundaries;
- Take a leading role in relevant change management including communication, expectation management, functional specification, implementation, planning and workflow re-engineering;
- Experience of supporting care pathways and digital projects across organisational and/or sector boundaries;
- Promote the use of information and information technology as an enabler for healthcare process design and re-design;
- Motivate staff of all levels within the Trust to adopt new systems and procedures;
- Persuade and negotiate when implementing new ways of working when there may be a resistance to change;
- Promote continuous quality improvement to deliver maximum benefits to patients, staff and business processes;
- Line manage named staff within the Clinical Application Service Team. All staff within the team work across all applications and therefore line managed staff will be accountable to other senior staff within the team for some of their day to day work;
- Undertake staff appraisals;
- Ensure essential training is maintained for managed staff;
- Contribute to the team “Comm Cell” as key communication tool;
- Work closely with Clinical Application Services Manager and Clinical Application Analysts colleagues, to prioritise team workload and assign resources to tasks accordingly, taking account of the knowledge, skills and level of responsibility required;
- Provide system management cover for Clinical Application Services Manager and Clinical Application Analysts colleagues in their absence;
- Ensure that the Clinical Application Services Team are sufficiently skilled and empowered with respect to the managed systems within their care to ensure that there is continuous system and user support for all applications throughout normal

service hours;
- Ensure that the Digital Training Team are updated with changes to applications and associated processes so that training and training materials can be maintained accordingly;
- Work with the Digital Training Manager to ensure that all staff using the systems are adequately trained and updated in a timely fashion;
- Ensure associated process and system changes across the Trust are effectively communicated.

INFORMATION RESOURCES

- Develop strategies to monitor, improve and promote input data quality;
- Work with the Information Asset Owner(s) to ensure regular audits of data;
- Ensure Trust managers and clinical directors are aware of, and fully utilise, any reporting functionality within the system to improve business intelligence and clinical informatics;
- Work with Business Intelligence, Clinical Coding and other Divisional colleagues to increase availability of information on system use, workload and system management to inform reporting cycles and service plans;
- Develop systems from user requirements documentation;
- The specification, design and development of Interfaces between disparate in house and 3rd party supplied systems, using both bespoke solutions and the Trust Integration Engine (TIE);
- Assist implementation of supplied or developed systems; ensure that departments and staff have appropriate processes in place to make effective use of these systems;
- Agree acceptance criteria for developed or supplied systems;
- Utilise system information effectively to monitor and report on the applications performance and support quality assurance.

RESEARCH AND DEVELOPMENT

- Undertake requirements analyses, carry out research, gather, collate and present findings which accurately reflect the needs of stakeholders.
- Carry out system testing.

FREEDOM TO ACT

- This role reports to a Line Manager, but may be involved in projects and therefore require reporting to Project/Service Managers;
- Manage own time effectively to prioritise competing demands, generally working with minimal supervision;
- Own assigned tasks to successful completion;
- May be required to undertake other appropriate duties as required by Line Management;
- React rapidly, calmly, professionally and effectively to unexpected issues;
- Dealing effectively with uncertain and complex situations and optimising opportunities, but understanding the need to seek clarity when unsure.

OTHER RESPONSIBILITIES

To take part in regular performance appraisal.

To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling.

To contribute to and work within a safe working environment.

The post holder is expected to comply with Trust Infection Control Policies and conduct

him/herself at all times in such a manner as to minimise the risk of healthcare associated infection.

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota.

APPLICABLE TO MANAGERS ONLY

- Be the Subject Matter Expert for all aspects of digital services delivery for the Trust;
- All managers hold the responsibility of the health and safety and wellbeing of their staff.

THE TRUST- VISION AND VALUES

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

Honesty, Openness & Integrity
Fairness,
Inclusion & Collaboration
Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call: 01392 207462.

PERSON SPECIFICATION

POST	Senior Clinical Application Analyst
BAND	7

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING		
• Educated to Degree level or equivalent professional experience, skills and training in a relevant discipline	X	
• Evidence of continuous professional development to post-graduate Diploma level	X	
• IT Service Delivery Methodology		X
• Qualified by experience and through evidence of personal development to work at senior level in Health and/or Social Care	X	
KNOWLEDGE/SKILLS		
• Knowledge of clinical systems used in Healthcare and detailed understanding of system administration	X	
• Knowledge of clinical practice within a hospital environment		X
• Evidence knowledge of the concepts of healthcare process design/ re-design and the role of information and information technology as an enabler for this		X
• Evidenced skills in solution design, costing, development, deployment and support	X	
• Evidenced knowledge of application development and software languages	X	
• Change management skills and demonstrable experience of bringing order to complex situations and maintaining focus on key objectives	X	
• Management skills to co-ordinate and direct personnel from different disciplines and with differing viewpoints and achieve pragmatic consensus	X	
• Ability to produce and deliver, or receive and process, detailed complex and highly sensitive information.		X
• Numerate with high level of computer literacy	X	
• Well-developed analytical and problem solving skills	X	
• Able to plan User Group meetings and lead consultations with staff groups	X	
EXPERIENCE		
• Working with staff at all levels across a multidisciplinary Healthcare oriented team	X	
• Demonstrable experience of working in multiple specialty settings, with evidence of understanding and supporting their workflows	X	
• At least 4 years' experience of supporting users of patient-based systems and/or maintaining such systems in a system analysis, system testing or system training capacity	X	
• Experience of managing system upgrades	X	
• Experience of testing system changes and upgrades	X	
• Relevant experience of change management including evidence of; communication, expectation management, functional specification, implementation, planning and workflow re-engineering	X	

• Experience of supporting care pathways and IM&T projects across organisational and/or sector boundaries	X	
PERSONAL ATTRIBUTES • Effective team player • Proven team leadership ability • Able to work on own initiative and manage a challenging workload • Able to work to deadlines • Consistent, reliable attendance • Outstanding communication skills both written and verbal • Proven ability to interact effectively with staff at all levels, both clinical and non-clinical • Credible, convincing and trust-inspiring manner • Enthusiastic, responsive to new demands, willing to learn new skills and welcome change • Ability to interpret national guidelines, advising colleagues accordingly, and planning change management strategies to ensure system/organisational compliance • Able to deal effectively with unexpected situations, take advantage of opportunities and overcome problems • Able to motivate and manage system support staff	 X X X X X X X X X X X X	
OTHER REQUIRMENTS • Demonstrates ambition and clear personal career planning • Flexible to the requirements of the role • There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota • Requirement to travel to other sites as required • Car Driver	 X X X X X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y		X		
Food handling	N				
Night working	Y	X			
Electrical work	N				
Physical Effort	Y	X			
Mental Effort	Y				X
Emotional Effort	Y			X	
Working in isolation	Y	X			
Challenging behaviour	Y		X		

COMPETENCY REQUIREMENTS

To be completed for all new positions
Please tick which of these essential learning s is applicable to this role
(**NB** those that are mandatory for all staff with no variation on frequency are pre-populated with a tick)

Safeguarding Children	Group 1	☐	Blood Transfusion	BDS18 collection	☐	Consent Training	☐
	Group 2	☐		BDS 19 & 20 Preparing & Administering	☐	VTE Training	☐
	Group 3	☐		BDS 17 Receipting	☐	Record management and the nhs code of practice	☐
	Group 4	☐		Obtaining a blood sample for transfusion	☐	The importance of good clinical record keeping	☐
	Group 5	☐		Annual Update	☐	Antimicrobial Prudent Prescribing	☐
	Group 6	☐				Control & Restraint Annual	☐
Not mapped this one		☐	Safeguarding Adults Awareness	Clinical Staff	☐	Mental Capacity/DOL's	☐
	Group 8	☐		Non Clinical Staff	☐		
Manual Handling – Two Year		☑	Falls, slips, trips & falls	Patients	☐		
Equality & Diversity – One-Off requirement		☑		Staff/Others	☐		
Fire	Annual	☑	Investigations of incidents, complaints and claims		☐		
	Two Yearly	☐	Conflict Resolution – 3 yearly		☐		
Infection Control/Hand Hygiene	Annual requirement	☐	Waterlow		☐		
	One-Off requirement	☐	PUCLAS		☐		
Information Governance		☑	Clinical Waste Management	Application principles for clinical staff	☐		
Harassment & Bullying (Self Declaration – One off requirement)		☑		Application principles for housekeeping	☐		
				Application principles for portering and waste	☐		

Proud to Care DEVON

WE WORK TOGETHER HOME . COMMUNITY . HOSPITAL

POSITIVE ABOUT DISABLED PEOPLE

Health & Wellbeing for RD&E staff

JOB DESCRIPTION

Royal Devon and Exeter
NHS Foundation Trust

"Our vision is to provide safe, high quality seamless service delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust Values"

JOB DETAILS	
Job Title	Clinical Application Analyst
Reports to	Senior Clinical Application Analyst
Band	6
National Job Profile used	IM&T Analyst Specialist/ Technical Engineer/ Team Leader
Department/Directorate	Digital Services Division

JOB PURPOSE

The Digital Services Division is committed to a culture of continual service improvement. The post holder will be an advocate for this culture across their service area, contributing to and demonstrating continual service improvement in the services for which they are responsible.

The purpose of this role is to be the senior system manager for a number of patient-based administrative and clinical applications. Based within a small team providing system management services for a range of departmental and enterprise wide clinical information systems, the Clinical Application Analyst provides cover and support for system managers of other applications and therefore requires an understanding of all systems supported by the team. The role includes:

- Responsibility for day to day management of the applications for which the post holder is assigned direct responsibility;
- Working with administration and clinical teams to deliver maximum benefit for patients through ongoing system optimisation to improve the efficiency and quality of the associated care pathways;
- As a senior member of the Clinical Application Services Team, involvement in the management and provision of a responsive and customer focused service to all clients within a Service Level Agreement (SLA) framework.

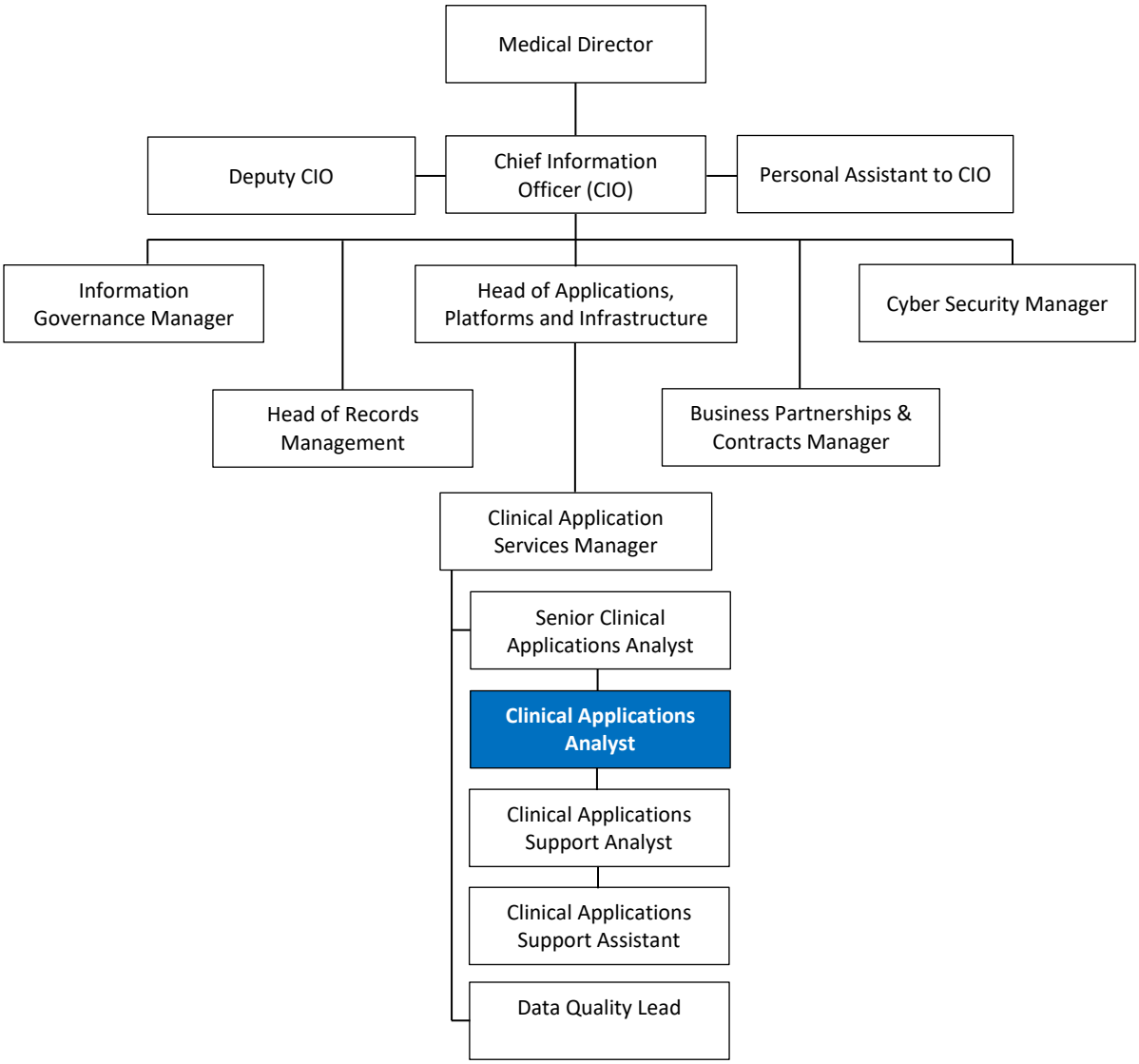
The post holder will:

- Be the assigned Clinical Application Analyst for some of the applications supported by the Team;
- Participate in the supervision and support of system analysts and assistants within the team as required;
- Demonstrate comprehensive knowledge and expertise in system management; and
- Support a broad range of system related service development, project and workflow development tasks as required.

KEY WORKING RELATIONSHIPS

Internal to the Trust	**External to the Trust**
Divisional Directors Trust Service Managers Information Asset Owners Digital Services Division Finance Department Procurement Department Internal Committees and Governance meetings Trust User Base	External Clients and Partners Epic technical experts and implementation team 3rd Party Service and Solution Providers NHS Digital Colleagues in other NHS and Social Care organisations

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

- Be responsible for the day to day management of a number of applications;
- Play a leading role in the implementation of new functionality across the Trust with specific focus on systems management and methodology;
- Ensure a standard based approach for all systems with respect to relevant Local and National policies, procedures and standards; including those for Records Management, Information Governance, Data Quality, Clinical Safety, Quality Assurance and Information Security;

- Work with developers and Suppliers to ensure system compliance with NHS Information Standards;
- Liaise with product suppliers to implement and test software systems upgrades in conjunction with Trust Digital Services Division colleagues to assure safe system changes with minimal disruption to users;
- Manage the progress of incidents, support calls, change requests and other aspects of the service to a successful and timely conclusion and where relevant in line with the contractual SLA;
- Manage system integrity and back office functions;
- Ensure maintenance of system and reference files ensuring compliance with best practice, Trust and National standards;
- Monitor and report on system availability in accordance with the Trust requirement to support 24 hours a day, 7 days a week system availability for users and, in conjunction with the system suppliers and the Applications, Platforms and Infrastructure Services Team, be responsible for maintaining availability of the team's portfolio of applications;
- Under the supervision of the Information Asset Owner(s), to fulfil the role of Information Asset Administrator for the systems managed, and in this role, to maintain required system documentation and contribute to the maintenance of up to date system business continuity plans in conjunction with the Trust IT business continuity and disaster recovery plans, system level security policy and system information security risk assessment;
- Provide a responsive service across multidisciplinary teams, resolving problems in a timely manner;
- Maintain a resolution procedure which is reflected within the Trust escalation policy;
- Ensure accurate data is recorded within the systems to support performance targets identified local and national data submissions and returns including; Referral to Treatment Time, Cancer Waiting Times, CQUINs and System Performance;
- Foster links with counterparts at other hospitals for mutual support and to share best practice in the management and use of applications;
- Co-ordinate systems testing and documentation outcomes in a test report for audit and assurance in a manner consistent with good practice and compliant with specified Trust Standards;
- Work with the Digital Training Manager to develop robust training plans and support materials for routine training, service support and introduction of new functionality or applications;
- Support the user-base and co-ordinate systems support staff in the transition between different versions of a system or migration to a new platform;
- Act and be acknowledged as the Subject Matter Expert (SME) for relevant systems within the team's remit;
- With respect to business continuity, and disaster recovery; monitor and assess the viability of existing arrangements and advise on viable options for improvement;
- Work with clinical directorates and Trust management to identify and document existing functional specifications and support the development of new functional requirements to support evolving service frameworks and drive service improvement;
- Lead the design, development and maintenance of system protocols and procedures;
- Ensure timely and accurate reporting of system and team performance.

COMMUNICATION/RELATIONSHIP SKILLS

- Present highly complex and potentially contentious information to multidisciplinary groups;
- Develop and maintain strong communications and relationships across all potential users, particularly across clinical directorates to ensure the engagement of stakeholders and the successful integration of new clinical information systems into day to day working practices;

- Engage key stakeholders throughout implementation of new functionality and maintain this relationship throughout the system lifecycle;
- For the applications within the team's portfolio; act as the system suppliers' first point of contact in the Trust for the purposes of support and system management and co-ordinate/oversee ongoing communication between Trust staff and system suppliers to ensure issues are promptly and successfully managed to resolution;
- Develop good working relationships with system suppliers and maintain effective communication to ensure high quality day to day support and that ongoing system developments and implementation are managed smoothly with minimal achievable disruption to service and to users;
- Communicate clearly with managed staff, system management team colleagues, wider Digital Services Division colleagues and system suppliers on the functionality and design of both front end and internal system processes and the operational/business processes into which they fit;
- Ensure system maintenance and administration documentation is obtained from system suppliers and internal procedures and protocols are documented and maintained in an effective system library along with relevant system change, issue and service logs;
- With others, communicate a range of complex and sometimes controversial or sensitive issues, relating to the managed systems, to staff of all levels within the organisation in a supportive and positive manner;
- Maintain effective channels of communication across Divisions/Clusters within the Trust.

ANALYTICAL/JUDGEMENTAL SKILLS

- Act with a 'problem solving approach' in order to identify and communicate challenges within the system in a manner that facilitates successful resolution;
- Identify and interpret complex facts and scenarios to be presented to senior management and clinical staff;
- Maintain an in-depth understanding of system processes and internal configuration and how they relate to the experience of users to ensure that the system is best configured and optimised to support users in effective and efficient use of the system.

PLANNING/ORGANISATIONAL SKILLS

- The post holder will organise their own day to day activities;
- Take a lead role, where required working with Divisional Programme and Projects colleagues, in the planning and management of system implementation and upgrades, ensuring good communication and co-ordination between internal teams and system suppliers.

PHYSICAL SKILLS

- Ability to lift and carry Information Technology (IT) equipment on occasional basis.

PATIENT/CLIENT CARE

- Patient Contact in this role is incidental.

POLICY/SERVICE DEVELOPMENT

- Substantially contribute to enabling sustained service improvement and reducing waste in the system workflow;
- On-going review of workflow process to ensure effective use of the information technology within departments and clinical directorates;
- Identify viable options for system change with the potential to improve efficiency; realise benefit and increase resilience;
- Lead quality improvement initiatives, identifying areas where processes can be improved and in conjunction with Users and the Digital Training Manager, design new

processes to be trialled evaluated and implemented.

FINANCIAL/PHYSICAL RESOURCES

- Safe use of own and others IT equipment;
- Support secure and safe operation of the incident logging system;
- Support the preparation and submission of business cases for new developments that may arise from the process of delivering the Trust's digital services;
- May have to assume responsibility for safe use of equipment used by others when investigating incidents.

HUMAN RESOURCES

- Motivate staff of all levels within the Trust to adopt new systems and procedures;
- Persuade and negotiate when implementing new ways of working when there may be a resistance to change;
- Promote continuous quality improvement to deliver maximum benefits to patients, staff and business processes;
- Line manage named staff within the Clinical Application Services Team. All staff within the team work across all applications and therefore line managed staff will be accountable to other senior staff within the team for some of their day to day work;
- Undertake staff appraisals;
- Ensure essential training is maintained for managed staff;
- Contribute to the team "Comm Cell" as key communication tool;
- Work closely with Clinical Application Services Manager and Clinical Application Analysts colleagues, to prioritise team workload and assign resources to tasks accordingly, taking account of the knowledge, skills and level of responsibility required;
- Provide system management cover for Clinical Application Services Manager and Clinical Application Analysts colleagues in their absence;
- Ensure that the Clinical Application Services Team are sufficiently skilled and empowered with respect to the managed systems within their care to ensure that there is continuous system and user support for all applications throughout normal service hours;
- Ensure that the Digital Training Team is updated with changes to applications and associated processes so that training and training materials can be maintained accordingly;
- Work with the Digital Training Manager to ensure that all staff using the systems are adequately trained and updated in a timely fashion;
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- Develop strategies to monitor, improve and promote input data quality;
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RESEARCH AND DEVELOPMENT

- Undertake requirements analyses, carry out research, gather, collate and present findings which accurately reflect the needs of stakeholders.

FREEDOM TO ACT

- This role reports to a Line Manager, but may be involved in projects and therefore require reporting to Project/Service Managers;
- Manage own time effectively to prioritise competing demands, generally working with minimal supervision;
- Own assigned tasks to successful completion;
- May be required to undertake other appropriate duties as required by Line Management;
- React rapidly, calmly, professionally and effectively to unexpected issues;
- Dealing effectively with uncertain and complex situations and optimising opportunities, but understanding the need to seek clarity when unsure.

OTHER RESPONSIBILITIES

To take part in regular performance appraisal.

To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling.

To contribute to and work within a safe working environment.

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APPLICABLE TO MANAGERS ONLY

- Be the Subject Matter Expert for all aspects of digital services delivery for the Trust;
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We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race,

religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call: 01392 207462.

PERSON SPECIFICATION

POST	Clinical Application Analyst
BAND	6

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING		
• Educated to Degree level or equivalent professional experience, skills and training in a relevant discipline	X	
• Evidence of continuous professional development to post-graduate Diploma level	X	
• IT Service Delivery Methodology		X
KNOWLEDGE/SKILLS		
• Knowledge of clinical systems used in Healthcare and detailed understanding of system administration	X	
• Knowledge of clinical practice within a hospital environment		X
• Knowledge of Outpatient and/or Inpatient (acute hospital) clerical procedures		X
• Change management skills and demonstrable experience of bringing order to complex situations and maintaining focus on key objectives	X	
• Management skills to co-ordinate and direct personnel from different disciplines and with differing viewpoints and achieve pragmatic consensus	X	
• Ability to produce and deliver, or receive and process, detailed complex and highly sensitive information		X
• Numerate with high level of computer literacy	X	
• Well-developed analytical and problem solving skills	X	
• Able to plan User Group meetings and lead consultations with staff groups	X	
EXPERIENCE		
• Working with staff at all levels across a multidisciplinary Healthcare oriented team	X	
• Demonstrable experience of working in multiple specialty settings, with evidence of understanding and supporting their workflows	X	
• At least 3 years' experience of supporting users of patient-based systems and/or maintaining such systems in a system analysis, system testing or system training capacity	X	
• Experience of managing system upgrades	X	
• Experience of testing system changes and upgrades	X	
PERSONAL ATTRIBUTES		
• Effective team player	X	
• Proven team leadership ability	X	
• Able to work on own initiative and manage a challenging workload	X	
• Able to work to deadlines	X	
• Consistent, reliable attendance	X	
• Outstanding communication skills both written and verbal	X	
• Proven ability to interact effectively with staff at all levels, both clinical and non-clinical	X	
• Credible, convincing and trust-inspiring manner	X	
• Enthusiastic, responsive to new demands, willing to learn	X	

new skills and welcome change • Possess a good sense of humour and enjoy working with multi-disciplinary groups • Able to deal effectively with unexpected situations, take advantage of opportunities and overcome problems • Ability to interpret national guidelines, advising colleagues accordingly, and planning change management strategies to ensure system/organisational compliance • Able to motivate and manage system support staff	X X X X	
OTHER REQUIRMENTS • Demonstrates ambition and clear personal career planning • Flexible to the requirements of the role • There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota • Requirement to travel to other sites as required • Car Driver	X X X X X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	Y	X			
Electrical work	N				
Physical Effort	Y	X			
Mental Effort	Y				X
Emotional Effort	Y		X		
Working in isolation	Y	X			
Challenging behaviour	Y	X			

COMPETENCY REQUIREMENTS

To be completed for all new positions
Please tick which of these essential learning s is applicable to this role
(**NB** those that are mandatory for all staff with no variation on frequency are pre-populated with a tick)

Safeguarding Children	Group 1	☐	Blood Transfusion	BDS18 collection	☐	Consent Training	☐
	Group 2	☐		BDS 19 & 20 Preparing & Administering	☐	VTE Training	☐
	Group 3	☐		BDS 17 Receipting	☐	Record management and the nhs code of practice	☐
	Group 4	☐		Obtaining a blood sample for transfusion	☐	The importance of good clinical record keeping	☐
	Group 5	☐		Annual Update	☐	Antimicrobial Prudent Prescribing	☐
	Group 6	☐				Control & Restraint Annual	☐
Not mapped this one		☐	Safeguarding Adults Awareness	Clinical Staff	☐	Mental Capacity/DOL's	☐
	Group 8	☐		Non Clinical Staff	☐		
Manual Handling – Two Year		☑	Falls, slips, trips & falls	Patients	☐		
Equality & Diversity – One-Off requirement		☑		Staff/Others	☐		
Fire	Annual	☑	Investigations of incidents, complaints and claims		☐		
	Two Yearly	☐	Conflict Resolution – 3 yearly		☐		
Infection Control/Hand Hygiene	Annual requirement	☐	Waterlow		☐		
	One-Off requirement	☐	PUCLAS		☐		
Information Governance		☑	Clinical Waste Management	Application principles for clinical staff	☐		
Harassment & Bullying (Self Declaration – One off requirement)		☑		Application principles for housekeeping	☐		
				Application principles for portering and waste	☐		

Proud to Care DEVON

WE WORK TOGETHER HOME . COMMUNITY . HOSPITAL

POSITIVE ABOUT DISABLED PEOPLE

Health & Wellbeing for RD&E staff

JOB DESCRIPTION

Royal Devon and Exeter NHS Foundation Trust

"Our vision is to provide safe, high quality seamless service delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust Values"

JOB DETAILS	
Job Title	Data Quality Lead
Reports to	Clinical Application Services Manager
Band	Band 4
National Job Profile used	IM&T Analyst/ Technician
Department/Directorate	Digital Services Division

JOB PURPOSE

As the Data Quality Lead the post holder will work as part of a dynamic team in delivering effective data quality services and continual service improvements to support the Royal Devon and Exeter (RD&E) NHS Foundation Trust, its local business partners and external clients across the South West.

The purpose of the role is to be responsible for the leadership of the cross-cutting Data Quality Work-stream, engaging with Clinical Applications staff within the Digital Services Division and collaborating with Programme and Project delivery staff, with the aim of improving data quality, in accordance with policies and procedures, across the Trust's entire Digital Services application portfolio.

The Data Quality Lead is part of the Clinical Application Services Team and will be responsible for reviewing the Business-As-Usual operation, integration and maintenance of shared core data and central access control for Trust-wide clinical and administrative applications and other business applications that fall within the remit of the Service.

The post holder will contribute to the development of data quality and access processes to improve the efficiency of the Service and ensure that they are closely aligned with the Trust strategy and prioritised implementation and training requirements. The post holder will also be required to cover for colleagues across the Clinical Application Services Team to maintain provision of a customer focused and responsive service.

He/she will act as an advocate for the systems, being tenacious in striving for improvements in ways of working in order to provide a better service for users whilst ensuring the effective delivery and operation of all applications, platforms and infrastructure at all times.

The Digital Services Division aims to develop a culture of continual service improvement. The post holder will be an advocate for this culture across the service area and demonstrate continual service improvement in the services for which they are responsible.

KEY WORKING RELATIONSHIPS

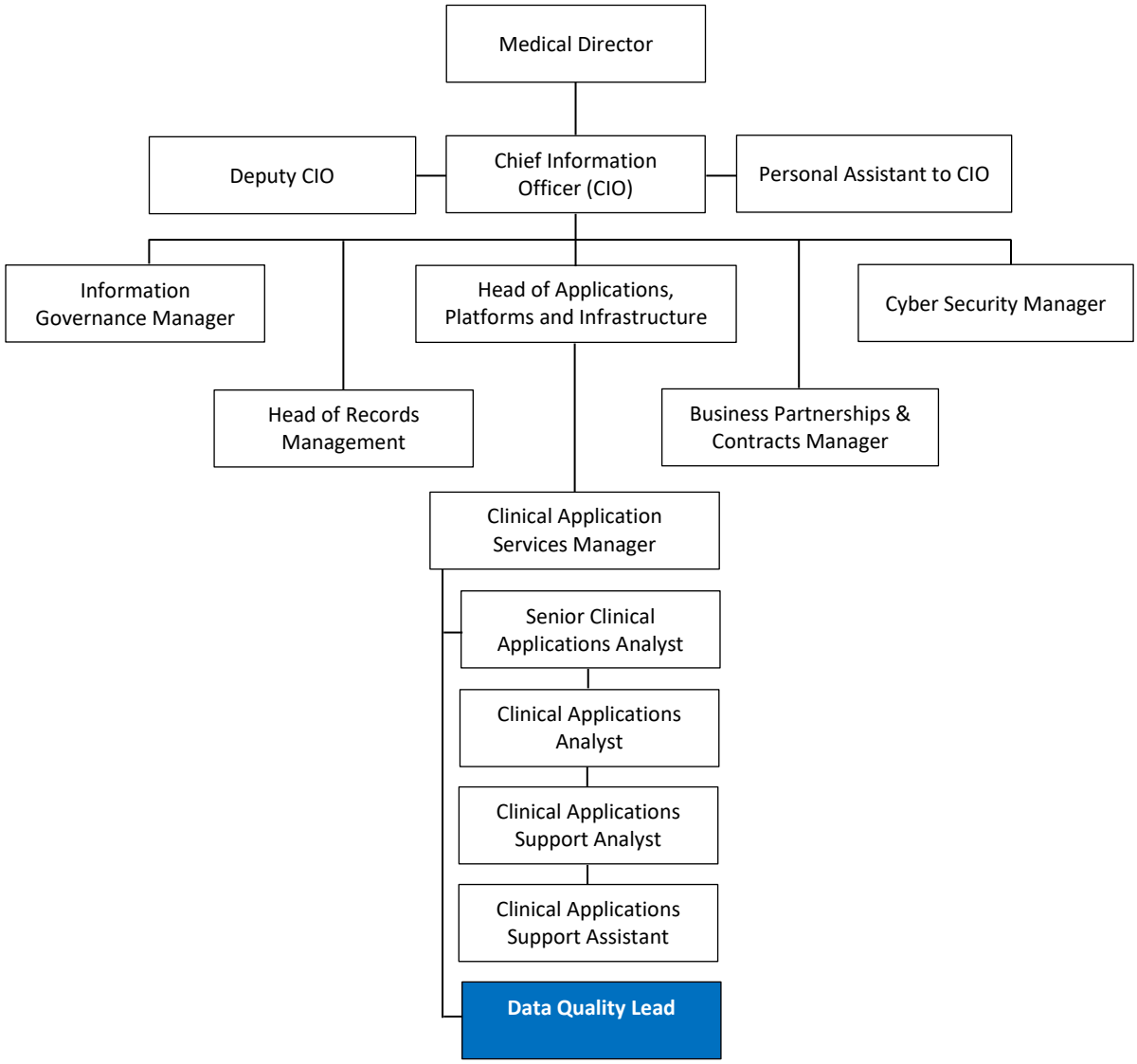
Internal to the Trust

Trust Service Managers
Information Asset Owners
Caldicott Guardian(s)
Subject Matter Experts (SMEs)
RD&E Talent and Learning Team
Digital Services Division Staff
Communications and Engagement
Internal Committees and Governance meetings
Clinician Staff
Trust IM&T User Base

External to the Trust

External Clients and Partners
3rd Party Service and Solution Providers
NHS Digital and NHSX
NHS England and NHS Improvement
Colleagues in other NHS and Social Care organisations

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The key result areas for the role are described in the following sections:

COMMUNICATION/RELATIONSHIP SKILLS

- Produces timely and accurate oral and written communications to relevant parties, such as reports to senior management, client/users, and staff groups;

- Presents complex and technical information clearly and concisely, adapting communication style to meet the needs of a variety of audiences;
- Respond to user requests relating to data quality, as well as system access, application support and digital training, providing first line system support to users at all levels, responding in a positive and timely manner to day to day faults and system/operator errors and issues;
- Build good relationships with a cross-section of users at individual and departmental levels;
- Together with colleagues, and working with users, the post holder will seek to improve on the levels of data quality in relation to all core clinical systems;
- Liaise and work with colleagues in the support teams and the Digital Training Service to proactively raise data quality issues and possible areas for improvement;
- Liaise as necessary with the Trusts Service Desk staff and Clinical Application Services staff to resolve issues;
- Respond positively to user requests when issues are reported, ensuring that team processes and standards, including response and resolution times, are adhered to;
- Provide, when required, first line access support at all levels, responding in a positive and timely manner to day to day system access issues;
- Collates complex information for formal reporting and presentations;
- Ensure that all communications both within and outside the Trust are of the highest standard, ensuring the meaning is clear and unambiguous.

ANALYTICAL/JUDGEMENTAL SKILLS

- Analyse situations and information to identify and resolve a range of problems including user errors/training issues, data quality issues and mismatches between system functionality and administrative or clinical processes;
- Ensure that any issues/faults that cannot be resolved are escalated in a timely manner to the Clinical Application Services Manager.

PLANNING/ORGANISATIONAL SKILLS

- Assist the Clinical Application Services Manager in the prioritisation of the data quality and access workload;
- Provides support to divisional team managers, programme or project managers, ensuring consistency of data quality approach across the area of provision;
- Participate in formulating, monitoring and maintaining data quality and access standards;
- Develop and maintain an in-depth knowledge of the Trust's clinical and business application portfolio, including the links with other Trust-wide and departmental clinical systems and an understanding of the impact of data quality on patient care and clinical safety;
- Maintain a detailed understanding of the role of the Clinical Applications Support Analysts and Assistants engaged in improving Trust-wide data quality;
- Accurately record details of all support calls where required, including issues and resolutions in accordance with internal ticket handling procedures and standards;
- Undertake a range of system maintenance tasks across multiple systems as required. These activities require a considerable degree of concentration, precision and analysis;
- Take part as required in accreditation and audit reviews.

PHYSICAL SKILLS

- A combination of sitting, standing and walking;
- Occasional requirement to carry and set up equipment for conference calls and presentations;
- Frequent requirement for concentration for checking documents/data and writing reports.

- Frequent requirement to use VDU equipment;
- Advanced keyboard skills.

PATIENT/CLIENT CARE

- Patient Contact in this role is incidental.

POLICY/SERVICE DEVELOPMENT

- Develops and implements improvements to data quality reporting processes to ensure it is produced efficiently to meet organisational and key stakeholder requirements, whilst ensuring audit compliance;
- Maintains an up to date awareness of NHS and Trust policies;
- Ensure that processes for maintaining effective data quality are efficient, based upon sound IT-design (validation and verification) principles and timely;
- Working within a framework of policies and procedures, maintain appropriate documentation to support the processes relating to application data quality and access and assist the Clinical Application Services Manager in ensuring the maintenance of such documentation across the Clinical Application Services Team;
- Ensure all work is completed in adherence to Information Governance standards, the Data Security Protection Toolkit (DSPT) and all relevant Trust policies and procedures, including but not limited to those relating to system access, security, deceased patient protocols, merging patients and double registration;
- To contribute to and work within safe working environment acting promptly in accordance with Trust Health and Safety policies and procedures in the event of risk to self and others;
- Contribute to the process of service change to ensure the most effective use of digital technology;
- Undertake the role of Advanced Registration Authority Agent, working within all national and local RA policy and procedure requirements;
- For the safety of patients, preserve the principle of no access to systems without training while seeking to ensure that staff have access to all the applications they need to support their work.

FINANCIAL/PHYSICAL RESOURCES

- Safe use of own and others IT equipment;
- Support secure and safe operation of the applications access database;
- Secure management of new Smartcards prior to and up to the point of issue.

HUMAN RESOURCES

- Ensure that knowledge across all support systems is shared and maintained, to include future system developments and best practice, and provide support, guidance and knowledge sharing to all members of the team on all aspects of the service, but particularly in relation to data quality;
- Lead on the design, development and maintenance of data quality-related Standard Operating Procedures (SOPs);
- Provide cover for colleagues in the event of planned or unplanned leave;
- Contribute to, and work within, a safe working environment, acting promptly in accordance with Trust Health and Safety policies and procedures in the event of risk to self and others;
- Recognise the importance of people's rights and act in accordance with legislation and Trust policies and procedures;
- Liaise with the Trust's Digital Training Service in developing/updating application training documentation;
- Ensuring team members complete required and essential (mandatory) learning as required;
- The post holder will take part as required in Health Records Accreditation;

- Assignment manage applications staff within the Clinical Application Services Team, ensuring continuity and quality of service across the whole team.

INFORMATION RESOURCES

- Accurate information is essential to the data collection process; the post holder will be tenacious in promoting and maintaining accuracy in all data bases and systems supported;
- Provide routine and ad hoc reports for key performance indicators and day to day team management relating to all aspects of data quality, e.g. NHS Number non-matches, numbers of data fixes performed, postcode errors fixed GP errors fixed, as required by their manager;
- Undertake system audits as required on access control and other aspects of application use, in accordance with agreed procedures;
- To record and update a database of system support calls and highlight system related issues and additional training needs;
- The post holder will accurately record details of all access support calls including issues and resolutions in accordance with local policies and, where appropriate, Trust Service Desk and Incident/Problem management procedures;
- All staff have a responsibility for data quality and for ensuring all data, both written and electronic, is recorded accurately and in a timely manner.

RESEARCH AND DEVELOPMENT

- Together with colleagues, and working with users, the post holder will seek to improve on the levels of data quality in relation to all clinical applications;
- To record and update a database of system support calls and highlight system related issues and additional training needs;
- Liaise as necessary with internal IT Service Desk staff and Clinical Application Services staff to undertake root cause analysis and resolve issues.
- Undertakes data quality audits and project/programme implementation compliance, such as for risk management.

FREEDOM TO ACT

- Working in accordance with all local policies and procedures and national requirements, use own initiative to deal with routine issues, while being aware that non-routine enquiries should be escalated and referred to their line manager or the appropriate system manager;
- Prioritise own workload and oversee prioritisation of workloads of managed staff, while remaining flexible and responding to the needs of the service.

OTHER RESPONSIBILITIES

To take part in regular performance appraisal.

To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling.

To contribute to and work within a safe working environment.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection.

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy)

up to and including dismissal.

There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota.

APPLICABLE TO MANAGERS ONLY

- N/a.

THE TRUST- VISION AND VALUES

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

- Honesty, Openness & Integrity
- Fairness,
- Inclusion & Collaboration
- Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

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POST	Data Quality Lead
BAND	4

PERSON SPECIFICATION

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING		
• A relevant diploma or experience in Health Records	X	
• Minimum 4 'O' Levels GCSE grade C or above, including Mathematics and English	X	
• ECDL qualification or equivalent		X
KNOWLEDGE/SKILLS		
• Minimum 3 years practical Health Records/patient-based systems procedures experience	X	
• Understanding of the purpose of system access control	X	
• User knowledge at a higher level of the clinical and business applications and/or other patient-based information systems	X	
• Willingness to undertake ongoing professional development	X	
• Ability to prioritise workload to respond to changing demand	X	
• Proven ability to motivate staff and encourage teamwork	X	
• Prior knowledge of Trust currently supported systems	X	
• Awareness of contemporary digital healthcare strategies	X	
• Excellent, proven verbal and written skills	X	
EXPERIENCE		
• Previous experience of supervision of staff including recruitment, appraisals and sickness management	X	
• Good keyboard skills	X	
• Experience of MS Windows and MS Office applications in an administrative capacity	X	
• Excellent interpersonal communication skills with staff at all levels	X	
• Likeable and outgoing nature	X	
• Analytical approach to problem solving	X	
• Ability to work on own imitative and manage own workload	X	
• Proven teamwork experience	X	
PERSONAL ATTRIBUTES		
• A calm, reassuring and patient manner	X	
• Empathetic and respectful of others	X	
• Fastidious attention to detail	X	
• Trustworthy	X	
• High level of personal integrity	X	
• Helpful, positive, "can do" attitude	X	
• Enthusiastic, responsive to new demands and willing to learn new skills	X	
• Welcoming of change and quick to adapt to new situations	X	
• Flexible	X	
• Motivated	X	
• Able to work to deadlines	X	
• Able to organise own workload	X	
• Smart appearance	X	
• Committed to service improvement	X	

• Sense of humour • Be willing to support users in a clinical environment e.g. ED, Radiology, Theatres	X X	
OTHER REQUIRMENTS • There will be a requirement to work evenings and weekends to meet deadlines and to participate in a 24/7 and/or on call rota • Able to work flexible hours to support staff across different shift patterns • Demonstrates ambition and clear personal career planning • Flexible to the requirements of the role • Requirement to travel to other sites as required • Clean driving licence with use of own car	X X X X X X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y		X		
Food handling	N				
Night working	N				
Electrical work	N				
Physical Effort	Y	X			
Mental Effort	Y				X
Emotional Effort	Y			X	
Working in isolation	N				
Challenging behaviour	Y		X		

COMPETENCY REQUIREMENTS

To be completed for all new positions
Please tick which of these essential learning s is applicable to this role
(**NB** those that are mandatory for all staff with no variation on frequency are pre-populated with a tick)

Safeguarding Children	Group 1	☐	Blood Transfusion	BDS18 collection	☐	Consent Training	☐
	Group 2	☐		BDS 19 & 20 Preparing & Administering	☐	VTE Training	☐
	Group 3	☐		BDS 17 Receipting	☐	Record management and the nhs code of practice	☐
	Group 4	☐		Obtaining a blood sample for transfusion	☐	The importance of good clinical record keeping	☐
	Group 5	☐		Annual Update	☐	Antimicrobial Prudent Prescribing	☐
	Group 6	☐				Control & Restraint Annual	☐
Not mapped this one		☐	Safeguarding Adults Awareness	Clinical Staff	☐	Mental Capacity/DOL's	☐
	Group 8	☐		Non Clinical Staff	☐		
Manual Handling – Two Year		☑	Falls, slips, trips & falls	Patients	☐		
Equality & Diversity – One-Off requirement		☑		Staff/Others	☐		
Fire	Annual	☑	Investigations of incidents, complaints and claims		☐		
	Two Yearly	☐	Conflict Resolution – 3 yearly		☐		
Infection Control/Hand Hygiene	Annual requirement	☐	Waterlow		☐		
	One-Off requirement	☐	PUCLAS		☐		
Information Governance		☑	Clinical Waste Management	Application principles for clinical staff	☐		
Harassment & Bullying (Self Declaration – One off requirement)		☑		Application principles for housekeeping	☐		
				Application principles for portering and waste	☐		

JOB DESCRIPTION

Royal Devon and Exeter NHS Foundation Trust

"Our vision is to provide safe, high quality seamless service delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust Values"

JOB DETAILS	
Job Title	Clinical Application Support Assistant
Reports to	Clinical Application Analyst
Band	3
National Job Profile used	IM&T Analyst / Technician entry level
Department/Directorate	Digital Services Division

JOB PURPOSE

The Digital Services Division aims to develop a culture of continual service improvement. The post holder is responsible for contributing to this culture across the service area.

This post is working within a team of experienced digital professionals providing system administration and support for users of clinical and administrative hospital applications.

The post holder will undertake responsibilities across three main areas of work, and will specialise in one of these. The area of specialisation will define the reporting line for the individual post holder.

1. Support and maintenance of the Trust Master Patient Index and linked patient indexes within supported applications, ensuring that all data is accurate and up to date in order to facilitate safe patient care and satisfy Information Governance requirements. This includes validating and correcting patient level data in order for the Trust to report accurate data.

2. Maintenance of access control. Support and administration for applications within the remit of the service, including EPR, PAS, Pathology and Picture Archiving and Communications System (PACS) / Clinical Record Interactive Search (CRIS), including the day to day maintenance of hospital systems reference files.

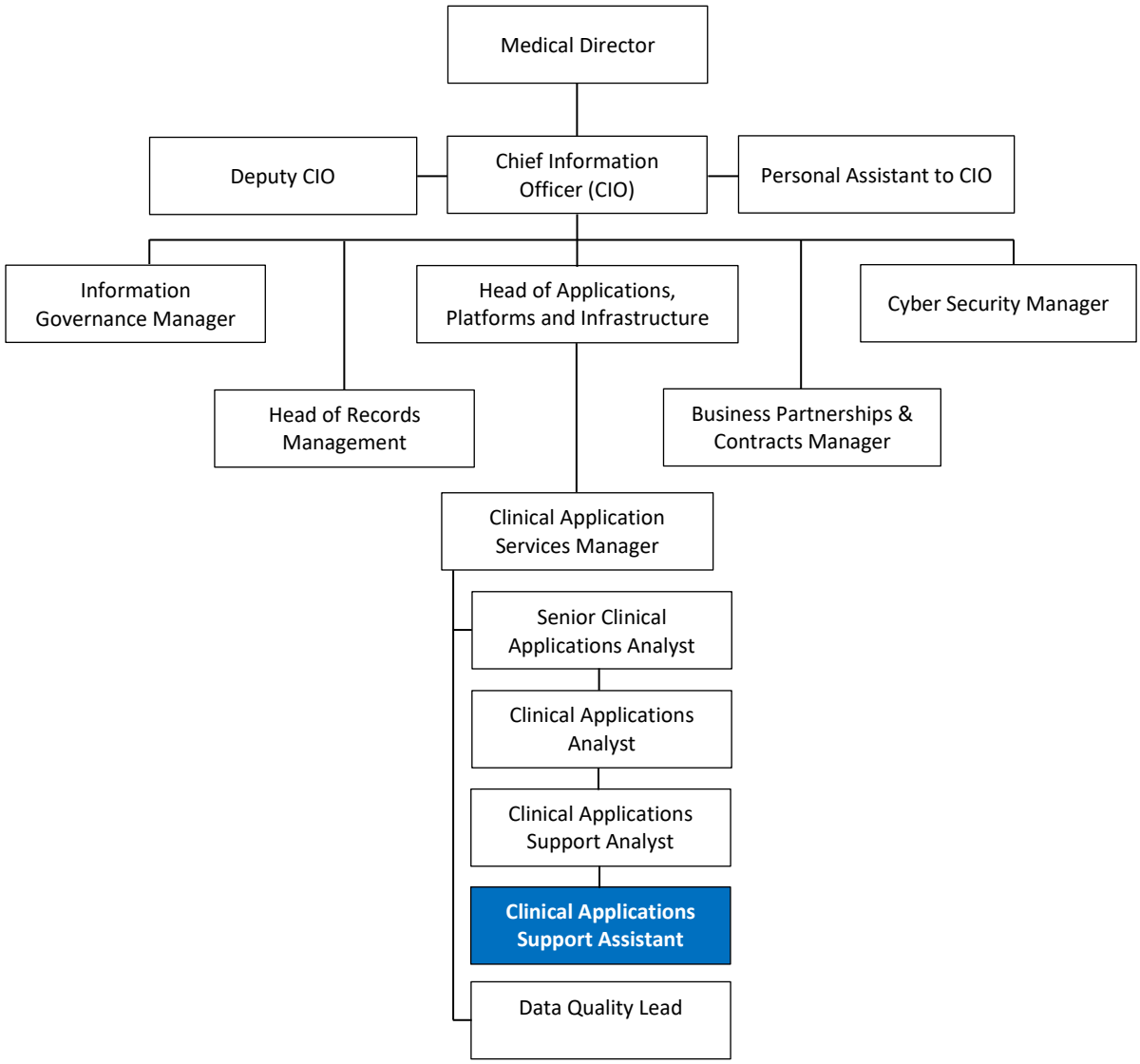
3. Administration and clerical support for the Digital Training Team who provide training for users of mainly patient based administrative and clinical applications.

The post holder will be required to cover for colleagues within the wider Applications, Platforms and Infrastructure Services Team and, when required, across the wider applications support teams to provide a highly patient focused and responsive service.

KEY WORKING RELATIONSHIPS	
Internal to the Trust	**External to the Trust**
Trust Service Managers Information Asset Owners	External Clients and Partners Epic technical experts and implementation

Digital Services Division Internal Committees and Governance meetings Trust User Base	team 3rd Party Service and Solution Providers Colleagues in other NHS and Social Care organisations

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

The key result areas for the role are described in the following sections:

COMMUNICATION/RELATIONSHIP SKILLS

- Respond to user enquiries providing first line support to users at all levels responding in a positive and timely manner, to day to day queries and system/operator errors and administration issues;
- Liaise with internal IT helpdesk engineers, desktop support and external system suppliers to ensure a timely resolution of faults and system errors;
- Ensure that any issues that cannot be resolved are escalated to the appropriate manager.

ANALYTICAL/JUDGEMENTAL SKILLS

- Monitor data quality, assess and where required undertake cleansing of master patient index and linked patient indexes across Trust applications to ensure the high standards on which patient safety relies are maintained;

- Refer enquiries to third parties where further investigation is required to confirm accuracy of source data before undertaking any amendments to Trust applications.

PLANNING/ORGANISATIONAL SKILLS

- The post holder will organise their own day to day activities;
- Respond effectively and within the Trust agreed target timescales to end user support queries logged on the RDE IT Service Desk;
- Maintain and update the GP reference file on multiple systems in a timely manner;
- Reprioritise workload as required to facilitate urgent requests; escalating to line manager where competing priorities could have an adverse effect on service delivery timescales;
- Contribute to ongoing Digital Services Division strategy development, its implementation and continuous improvement culture.

PHYSICAL SKILLS

- Ability to lift and carry Information Technology (IT) equipment on occasional basis;
- Advanced keyboard skills.

PATIENT/CLIENT CARE

- Patient Contact in this role is incidental.

POLICY/SERVICE DEVELOPMENT

- The post holder will prioritise their own workload;
- Working within a framework of policies and procedures, maintain appropriate documentation to support the processes;
- Participate in formulating, monitoring and maintaining data quality standards for all supported systems;
- Ensure all work is completed in adherence to Information Governance standards, the Data Protection Act and all relevant Trust policies and procedures, including those relating to system access, security, deceased patient protocols, merging patients, double registration;
- The post holder will have a duty of care in relation to all equipment and recourses used in the course of their work;
- Provide, when required, first line support at all levels, responding in a positive and timely manner to day to day system / user errors, faults and training issues;
- Together with colleagues, develop and maintain an in-depth knowledge of the supported systems, to support the role;
- Together with colleagues, and working with users, seek to improve on the levels of data quality and training in relation to all clinical systems;
- Ensure all work is carried out in line with both Trust and Health Records Policies and Procedures;
- Undertake any other duties commensurate with the grade as required by their line manager.

FINANCIAL/PHYSICAL RESOURCES

- Safe use of own and others IT equipment;
- Support secure and safe operation of the incident logging system.

HUMAN RESOURCES

- Ensure that knowledge across all support systems is shared and maintained, to include future system developments and best practice for all;
- Provide cover for colleagues in the event of sickness, leave or other periods of absence;
- Contribute to and work within safe working environment acting promptly in

accordance with Trust Health and Safety policies and procedures in the event of risk to self and others;
- Recognise the importance of people's rights and act in accordance with legislation and Trust policies and procedures;
- Liaise with the Trust's Digital Training team in developing/updating system training programmes and, when required, participate in the delivery of such training during new implementations and as part of user support.

INFORMATION RESOURCES

- Accurately record details of all support calls including issues and resolutions in accordance with local policies and, where appropriate, Trust Service Desk procedures;
- Assist in database management for supported systems, ensuring data quality by appropriate checks and established housekeeping routines;
- As required, monitor data quality and undertake cleansing of master patient index and linked patient indexes across Trust applications to ensure the high standards on which patient safety relies are maintained;
- Address inaccurate or incomplete demographics details of registered patients such as postcodes, registered GP, name, date of birth etc.;
- Reconcile NHS Number non-matches on the Master Patient Index and Patient Administration System;
- Maintain and update the GP reference file on multiple systems in a timely manner;
- Participate in internal and external audit, quality assurance and accreditation survey visits as required;
- All staff have a responsibility for data quality and for ensuring all data, both written and electronic, is recorded accurately and in a timely manner.

RESEARCH AND DEVELOPMENT

- Contribute to the process of service change to ensure effective use of information technology within the systems;
- Understand the business processes used and engage with colleagues, Trust Applications Trainers and system managers to obtain maximum process and service improvement from system functionality;
- Assist in the specification of system changes to support business processes;
- Undertake system implementation and training in new areas as appropriate, advocating the importance of accurate data recording and its contribution to patient care.

FREEDOM TO ACT

- Working in accordance with all local policies and procedures and national requirements, use own initiative to deal with routine issues, but will need to be aware that non-routine enquiries should be escalated and referred to their line manager or the appropriate system manager.

OTHER RESPONSIBILITIES

To take part in regular performance appraisal.

To undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling.

To contribute to and work within a safe working environment.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection.

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

THE TRUST- VISION AND VALUES

Our vision is to provide safe, high quality seamless services delivered with courtesy and respect. To achieve our vision we expect all our staff to uphold our Trust values. Our Trust values are:

Honesty, Openness & Integrity
Fairness,
Inclusion & Collaboration
Respect & Dignity

We recruit competent staff that we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

We are committed to recruiting and supporting a diverse workforce and welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. We expect all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call: 01392 207462.

PERSON SPECIFICATION

POST	Clinical Application Support Assistant
BAND	3

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING		
• Good level of English and Mathematics	X	
• European Computer Driving Licence (ECDL) or equivalent proven experience with computers using a variety of IT software	X	
KNOWLEDGE/SKILLS		
• User knowledge of one or more hospital or clinical information systems		X
• Using own initiative to solve problems	X	
• Meticulous in checking for accuracy, whilst working to deadlines	X	
• Understanding of the importance of data quality	X	
• Organised and methodical worker with the ability to work on own initiative as well as part of a team	X	
• Excellent interpersonal and communication skills (verbal and written) with a good telephone manner	X	
• Understanding of the workings of an Acute Trust		X
• Multi-Tasker	X	
EXPERIENCE		
• Experience in an application support capacity or as a user of one or more hospital or clinical applications		X
• An interest and desire to be involved in initiatives to develop and improve IT systems to better support patient care	X	
• Previous business administration experience	X	
• Previous experience in working in a busy environment and prioritising and managing own workload	X	
• Experience of working with staff at all levels across multidisciplinary teams	X	
PERSONAL ATTRIBUTES		
• Remain calm and professional in a busy environment	X	
• Flexible approach to work	X	
• Enthusiastic, responsive to new demands and willing to learn new skills	X	
• Welcoming of change and quick to adapt to new situations	X	
• Helpful, positive, “can do” attitude	X	
OTHER REQUIRMENTS		
• Demonstrates ambition and clear personal career planning	X	
• Flexible to the requirements of the role	X	
• Requirement to travel to other sites as required	X	
• Car Driver	X	
• Good attendance record/ employment record	X	
• Able to work flexible hours to support staff across different shift patterns	X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	Y	X			
Electrical work	N				
Physical Effort	Y	X			
Mental Effort	Y				X
Emotional Effort	Y	X			
Working in isolation	Y	X			
Challenging behaviour	N				

COMPETENCY REQUIREMENTS

To be completed for all new positions
Please tick which of these essential learning s is applicable to this role
(**NB** those that are mandatory for all staff with no variation on frequency are pre-populated with a tick)

Safeguarding Children	Group 1	☐	Blood Transfusion	BDS18 collection	☐	Consent Training	☐
	Group 2	☐		BDS 19 & 20 Preparing & Administering	☐	VTE Training	☐
	Group 3	☐		BDS 17 Receipting	☐	Record management and the nhs code of practice	☐
	Group 4	☐		Obtaining a blood sample for transfusion	☐	The importance of good clinical record keeping	☐
	Group 5	☐		Annual Update	☐	Antimicrobial Prudent Prescribing	☐
	Group 6	☐				Control & Restraint Annual	☐
Not mapped this one		☐	Safeguarding Adults Awareness	Clinical Staff	☐	Mental Capacity/DOL's	☐
	Group 8	☐		Non Clinical Staff	☐		
Manual Handling – Two Year		☑	Falls, slips, trips & falls	Patients	☐		
Equality & Diversity – One-Off requirement		☑		Staff/Others	☐		
Fire	Annual	☑	Investigations of incidents, complaints and claims		☐		
	Two Yearly	☐	Conflict Resolution – 3 yearly		☐		
Infection Control/Hand Hygiene	Annual requirement	☐	Waterlow		☐		
	One-Off requirement	☐	PUCLAS		☐		
Information Governance		☑	Clinical Waste Management	Application principles for clinical staff	☐		
Harassment & Bullying (Self Declaration – One off requirement)		☑		Application principles for housekeeping	☐		
				Application principles for portering and waste	☐		

Proud to Care DEVON

WE WORK TOGETHER
HOME . COMMUNITY . HOSPITAL

POSITIVE ABOUT DISABLED PEOPLE

Health & Wellbeing for RD&E staff

Royal Devon University Healthcare NHS Foundation Trust

JOB DESCRIPTION

JOB DETAILS	
Job Title	Data Quality Officer
Reports to	Information and Data Quality Manager
Band	4
Department/Directorate	Digital Services

JOB PURPOSE

Good data quality is essential for delivering high quality patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services.

The post holder will identify areas where data quality needs to be improved and the subsequent actions to be taken, and carry out corrections to hospital systems where incorrect or missing data are identified.

They will assist with the implementation and maintenance of data quality and assurance projects across the Trust, developing and adopting new sustainable solutions to ensure effective and measurable improvements are achieved in information and data quality.

KEY WORKING RELATIONSHIPS

The post holder is required to deal effectively with staff of all levels throughout the Trust as and when they encounter on a day to day basis. In addition the post holder will deal with the wider healthcare community, external organisations and the public. This will include verbal, written and electronic media.

Of particular importance are working relationships with:

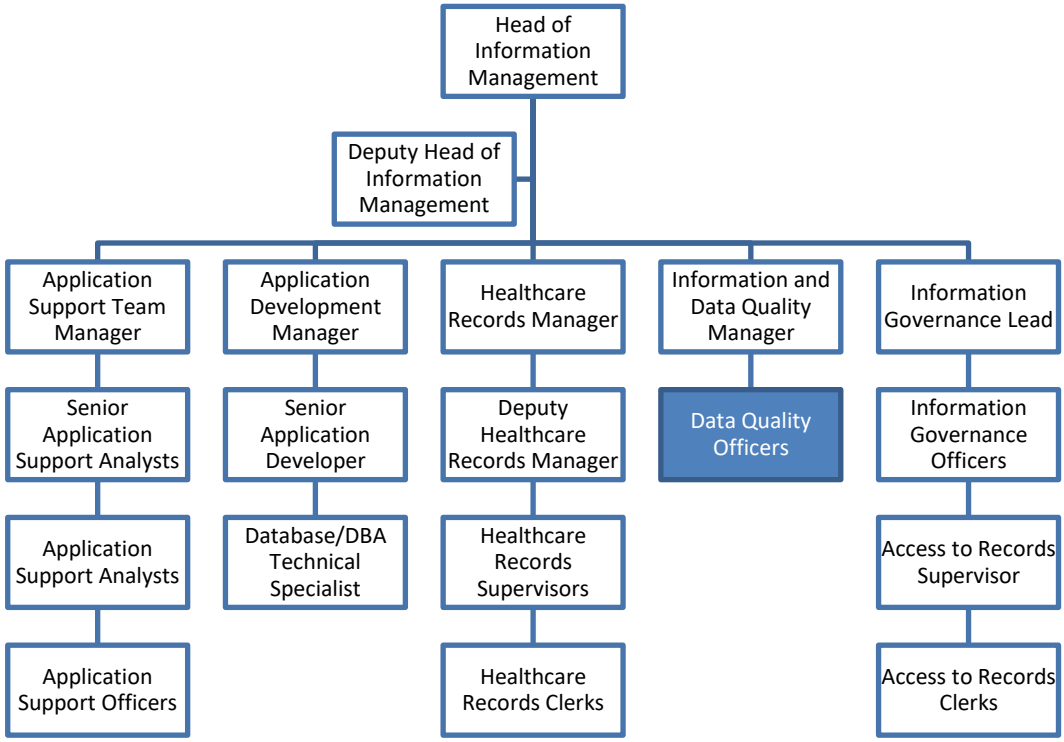
Internal to the Trust

- Clinical Staff
- Administrative Staff
- Service Managers
- Application Support
- Healthcare Records
- Business Intelligence
- Information Governance
- Digital Services
- Colleagues at RD&E Hospital

External to the Trust

- GP Practices
- Other NHS and Social Care organisations
- Epic technical experts
- NHS England
- NHS Digital

ORGANISATIONAL CHART



KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

- Monitor data quality workqueues in Epic and take the necessary action to resolve issues.
- Receive and manage chart correction tickets and liaise with other teams as necessary to resolve issues. Carry out corrections to Epic or other systems where incorrect or missing data are identified.
- Analyse information identifying areas of poor performance, trends of performance and providing benchmarks against other organisations.
- Monitor external data quality reports (e.g. SUS dashboards, DQMI, HED reports) to identify issues of data quality or completeness.
- Prepare and submit files to the Demographics Batch Service for batch tracing.
- Receive death notification reports and action them on Epic or other systems as necessary.
- Support the operational and corporate teams within the Trust in developing robust processes for data collection that are accurate and timely.
- Contribute to the development of a data quality culture in the organisation by highlighting data issues, working to develop solutions and ensuring routine audit / validation of all data.
- Identify and deliver training relating to staff capability to capture accurate, timely and complete data.
- Work with operational and corporate teams within the Trust to formulate and monitor improvement plans in relation to data quality.
- Conduct and assist in regular auditing to comply with the Data Quality Policy. Assist in ensuring the Data Quality Policy is implemented and the monitor the implementation of the policy.

- Develop data quality audit tools and using these to conduct ‘deep dive’ analyses into services to identify areas of poor data quality.
- Develop and produce routine internal and external reports ensuring key facts are reported.
- Manipulate data and produce relevant analysis using tools such as Excel and SQL, presenting the resulting analysis in a way that eases understanding and comprehension.
- Prepare reports for the Data Assurance Group. Present reports at the Data Assurance Group meetings and other governance groups as required.
- Bring to the attention of the Information and Data Quality Manager any serious matters relating to data quality or completeness.
- Ensure data are input within the rules laid down in the NHS Data Dictionary. Bring to attention of the Information and Data Quality Manager any guidelines, policies or practices that may be at odds with the NHS Data Dictionary.
- Follow guidelines for working with confidential data at all times. Respect the requirements of the General Data Protection Regulations 2018. Be aware of and work within the policies and procedures adopted by the Trust.
- Any other duties that may from time to time be required by the Information and Data Quality Manager.

FREEDOM TO ACT

- Work within standard operating procedures. Use initiative to deal with routine matters and complex queries, deciding when it is necessary to refer to the line manager.
- Work is managed rather than supervised and the post holder will organise own workload on a day to day basis.

COMMUNICATION/RELATIONSHIP SKILLS

- Complex communication with a range of people on complex matters.
- Adhere to the organisation’s standards of customer care. Courteously and efficiently receive enquiries, communicate effectively with staff at all levels internal and external to the organisation, either by telephone, email or receiving visitors in person, in a tactful and sensitive manner, respecting confidentiality at all times.
- Exchange confidential information with staff within partner agency organisations where agreement and co-operation are required. The post holder may also be expected to participate in consultation with staff relevant regarding changes to area of work.
- Behave in accordance with the Trust's values of demonstrating compassion, striving for excellence, respecting diversity, acting with integrity and to listen and support others.

ANALYTICAL/JUDGEMENTAL SKILLS

- Judgements on complex facts requiring interpretation and comparing options.
- Identify, analyse and evaluate data quality issues which may impact on information provision and, through experience, judge what action needs to be taken in terms of user input correction or whether further investigation is required to understand outcome variations.

- Follow up data quality issues with relevant teams. May require post-holder to suggest changes to working practices both within own department and Trust-wide as a result.

PLANNING/ORGANISATIONAL SKILLS

- Planning and prioritise own workload on an ongoing basis and adjust tasks or activities daily as the situation requires, escalating to line manager if necessary.
- Allocate work to other staff as appropriate, arranging staff cover as and when necessary.

PATIENT/CLIENT CARE

- Put the patient, as the first priority, at the centre of all activities. The post holder will have infrequent contact with patients/clients on the wards and will provide non-medical information and advice

POLICY/SERVICE DEVELOPMENT

- Follow Trust policies and participate in policy and service development. The post holder will propose changes and implement policies and working practices for own area.
- Support improvement planning processes working closely with managers to identify action plans and ensure that Trust governance processes are adhered to.

FINANCIAL/PHYSICAL RESOURCES

- Monitor stock levels of stationery, receive post and report maintenance faults.
- Ensure the efficient and effective use of all resources used within the course of one's own duties, maintaining an awareness of the financial impact of inappropriate use.

HUMAN RESOURCES

- Maintain and update own training relevant to post. Taking an active part in the development review of own work suggesting areas for learning and development in the coming year.
- Provide cover for other team members during periods of absence.
- Demonstrate duties to new starters, and allocate and check work of other data quality staff. Provide on the job training for new staff and work experience students.

INFORMATION RESOURCES

- Daily use of information systems relevant to the work area to produce documents and reports; input, store and maintain information. Analysing information on a daily basis.
- May be required to assist in modifying systems and processes.

RESEARCH AND DEVELOPMENT

- Comply with Trust's requirements and undertake surveys as necessary to own work.

PHYSICAL SKILLS

- Advanced keyboard skills to operate a range of computer software.

PHYSICAL EFFORT

- Light physical effort. Computer and VDU use for the majority of the working day.

MENTAL EFFORT

- Frequently required to concentrate for long periods of time.
- The work pattern is unpredictable, with frequent interruption to deal with queries on a range of matters.

EMOTIONAL EFFORT

- Occasionally manage difficult situations, which may need to be referred to a senior member of staff. Rare exposure to distressing information.

WORKING CONDITIONS

- Working in an office environment using computer equipment for long periods.

OTHER RESPONSIBILITIES

Take part in regular performance appraisal.

Undertake any training required in order to maintain competency including mandatory training, e.g. Manual Handling

Contribute to and work within a safe working environment

You are expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

You must also take responsibility for your workplace health and wellbeing:

- When required, gain support from Occupational Health, Human Resources or other sources.
- Familiarise yourself with the health and wellbeing support available from policies and/or Occupational Health.
- Follow the Trust's health and wellbeing vision of healthy body, healthy mind, healthy you.
- Undertake a Display Screen Equipment assessment (DES) if appropriate to role.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, we reserve the right to insist on changes to your job description after consultation with you.

Everyone within the Trust has a responsibility for, and is committed to, safeguarding and promoting the welfare of vulnerable adults, children and young people and for ensuring that they are protected from harm, ensuring that the Trusts Child Protection and Safeguarding Adult policies and procedures are promoted and adhered to by all members of staff.

PERSON SPECIFICATION

Job Title	Data Quality Officer
Band	4

Requirements	Essential	Desirable
QUALIFICATION/ SPECIAL TRAINING		
• Educated to GCSE Grade C or above in Mathematics and a range of other subjects including English	X	
• NVQ 3 Business Administration or Statistics or equivalent qualification or experience	X	
• ECDL or other IT qualification		X
KNOWLEDGE/SKILLS		
• Very good IT skills	X	
• Good working knowledge of Microsoft Excel and other Microsoft Office and web-based packages	X	
• Able to follow complex instructions	X	
• Able to analyse, interpret and present complex information from large data sets	X	
• Able to work with a high degree of accuracy and to demonstrate attention to detail	X	
• Good understanding of data quality issues	X	
• Knowledge of basic statistics	X	
• Knowledge of NHS data definitions		X
• Knowledge of Microsoft Access/SQL and programming techniques		X
• Good presentation skills		X
EXPERIENCE		
• Significant clerical/administrative experience within customer care environment or similar	X	
• Experience in an analytical role servicing information requirements in a complex environment		X
• Experience of report design and production		X
• Previous NHS experience		X
• Experience of using NHS hospital systems		X
PERSONAL ATTRIBUTES		
• Excellent interpersonal and communication skills, both written and verbal, with a wide range of people	X	
• Able to plan and prioritise own workload and meet deadlines	X	

• Able to maintain high levels of concentration for long periods of time	X	
• Good organisational skills	X	
• Able to work independently and as part of a Team	X	
• Flexible and adaptable to change	X	
• Able to demonstrate a diplomatic caring attitude whilst maintaining confidentiality	X	
OTHER REQUIREMENTS • The post holder must demonstrate a positive commitment to uphold diversity and equality policies approved by the Trust	X	
• Willing to undertake training relevant to the post	X	
• Able to travel to other locations as required	X	

WORKING CONDITIONS/HAZARDS		FREQUENCY (Rare/ Occasional/ Moderate/ Frequent) R	O	M	F
Hazards/ Risks requiring Immunisation Screening					
Laboratory specimens	N				
Contact with patients	N				
Exposure Prone Procedures	N				
Blood/body fluids	N				
Laboratory specimens	N				
Hazard/Risks requiring Respiratory Health Surveillance					
Solvents (e.g. toluene, xylene, white spirit, acetone, formaldehyde and ethyl acetate)	N				
Respiratory sensitisers (e.g isocyanates)	N				
Chlorine based cleaning solutions (e.g. Chlorclean, Actichlor, Tristel)	N				
Animals	N				
Cytotoxic drugs	N				
Risks requiring Other Health Surveillance					
Radiation (>6mSv)	N				
Laser (Class 3R, 3B, 4)	N				
Dusty environment (>4mg/m3)	N				
Noise (over 80dBA)	N				
Hand held vibration tools (=>2.5 m/s2)	N				
Other General Hazards/ Risks					
VDU use (> 1 hour daily)	Y				X
Heavy manual handling (>10kg)	N				
Driving	Y	X			
Food handling	N				
Night working	N				
Electrical work	N				
Physical Effort	Y	X			
Mental Effort	Y				X
Emotional Effort	Y		X		
Working in isolation	Y	X			
Challenging behaviour	Y	X			

Northern Devon Healthcare NHS
NHS Trust

Job Description

1. Job Details	
Job Title:	Information Systems & Data Quality Manager
Responsible to:	Head of Informatics
Professionally Responsible to:	Head of Informatics
Grade:	Band 7
Unit:	Information Services (Finance Directorate)

2. Job Purpose

Responsibility for the provision of accurate, relevant and timely information which is fit for purpose to enable effective clinical care, business planning, income recovery and performance management.

To manage the implementation and development of the *InView* data warehouse.

To promote the use of the *InView* data warehouse as an enterprise wide information and intelligence resource.

To contribute, with the Head of Informatics, to the development of an information driven culture within the Trust.

To ensure the continuity, timeliness and accuracy of national and local data flows to the Department of Health, Strategic Health Authorities and Commissioners.

Act as the Trust 'expert' on data definitions, Contract Data Sets and benchmarking.

Manage the Data Quality team.

Contribute to the development of an information systems strategy to meet the Trust's current and future business needs.

3. Dimensions

The provision of data to support the corporate requirements for information.

The maintenance of data flows.

Promoting all aspects of information use and business intelligence across the Trust.

All aspects of the development of the data warehouse as the information hub of the organization.

Provision of data and definitions advice across the organization.

4. Organisational Chart

Head of Informatics
|
Information Systems & Data Quality Manager
|
Data Quality Officers

5. Main Tasks/Duties and Areas of Responsibility

Information Management

1 Working with the Head of Informatics lead the development of the *InView* data warehouse. This will be aligned with corporate information needs identified by the postholder.

2 To be responsible for both internal data set delivery – Finance, Performance Management and the Dashboard and the external requirements - SUS, CCG etc.

3 To ensure full compliance with the Data Dictionary and the Data Manual.

4 Responsible for developing Information policies and strategies across the Trust.

5 Identify information 'gaps' and ensure the development/procurement of minor applications to address these areas.

6 Liaise with Finance, Clinical, Performance Management and Operational staff to ensure that corporate information requirements are being met.

7 Provide an input into the SmartCare project to ensure that the new applications can support the Trust's information requirements.

8 In conjunction with the Head of Informatics work towards the establishment of a new information culture.

Data Quality

9 To lead on data quality issues, and work with the Head of Informatics to achieve the highest standards of data quality.

10 Undertake regular audits in relation to the implementation of TrakCare around 'encounter slice' selection.

11 Develop validation processes to support TrakCare implementation and 18 Week Wait monitoring/management.

12 Monitor external data quality reports (e.g. SUS dashboards, Dr Foster, HES reports) to identify issues of data quality or completeness.

13 Ensure the implementation and compliance with the Data Quality policy.

General

14 Management of all staff within the functions listed above including recruitment, appraisal, continuing professional development and disciplinary actions according to Trust policies/guidelines.

15 Responsible for the management of the budgets associated with the above functions including being an authorized signatory.

16 Deputise for the Head of Informatics on Information matters as and when required.

17 Represent the Trust on all matters relating to the above listed functions at relevant external meetings e.g. SHA, PCT etc.

6. Communication and Working Relationships

Internal Relationships

Communication and co-operative working for all the above areas with;

- Clinical and Executive Directors
- General and other Senior Managers
- Finance and Performance Management Teams
- Clinical staff
- Administrative staff

External Relationships

- Devon CCG
- Cornwall CCG
- Devon County Council
- Other NHS Trust staff
- NHS Improvement
- InterSystems
- CACI (Data Warehouse provider)
- Department of Health
- NHS Digital

Northern Devon Healthcare NHS
NHS Trust

Person Profile

Job Title:	Information Systems & Data Quality Manager
Grade:	Band 7
Department:	Informatics (Finance Directorate)

Criteria Required	Essential	Desirable
Qualifications & Training	Educated to degree level and at least 3 years experience of NHS Informatics. Masters Degree qualification in an informatics related discipline. Advanced computer skills and literacy (MS desktop applications).	Management within a Health Informatics environment. Relevant Post Graduate qualification.
Specific Knowledge & Skills	Working knowledge of Data Dictionary, Data Manual and CDS Manual. Working knowledge of *Payment by Results*. PAS and other health applications. Knowledge of SQL, XML and Business Objects. In depth understanding of SUS requirements.	Knowledge of NPfIT, Choose & Book and other NHS policies and programmes. Working knowledge of PRINCE2. Planning and implementation of application interfaces. Data warehouse and repositories. Working within a project team.
Special Experience	Translation of DSCN's into practical action eg 18 week wait (RTT).	
Physical Skills & Effort	No special physical skills required	
Mental Effort	Considerable at times. There will be frequent interruptions as there is	

	a need to provide a day to day service in addition to the planning and research elements of the role. Detailed planning of projects and implementation requires an exacting attention to detail.	
Emotional Effort	There is need to be emotionally robust. There is also a need to be assertive at times.	
Requirements due to working environment	There are no special requirements.	

Royal Devon and Exeter NHS
NHS Foundation Trust

JOB DESCRIPTION

The Trust is committed to recruiting and supporting a diverse workforce and so we welcome applications from all sections of the community, regardless of age, disability, gender, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status. The Trust expects all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

1. JOB DETAILS:

Job Title: Information Governance Officer

Band: 4

Reports to: Senior Information Governance Officer

Accountable to: Deputy Information Governance Manager

Department / Division: **Information Governance/IM&T**

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director

2. JOB PURPOSE:

The post holder is responsible for the supervision of the day –to- day running of the Information Governance Office to ensure an efficient and effective service is provided to the Trust and outside agencies, in the provision of processing all requests for data held by the Trust, within the guidelines of the Data Protection Act 1998 (DPA), Access to Health Records Act 1990 (AtHRA) and Freedom of Information Act 2000 (FOI).

The post holder will provide support in co-ordinating the completion of the Information Governance Toolkit.

3. KEY WORKING RELATIONSHIPS:

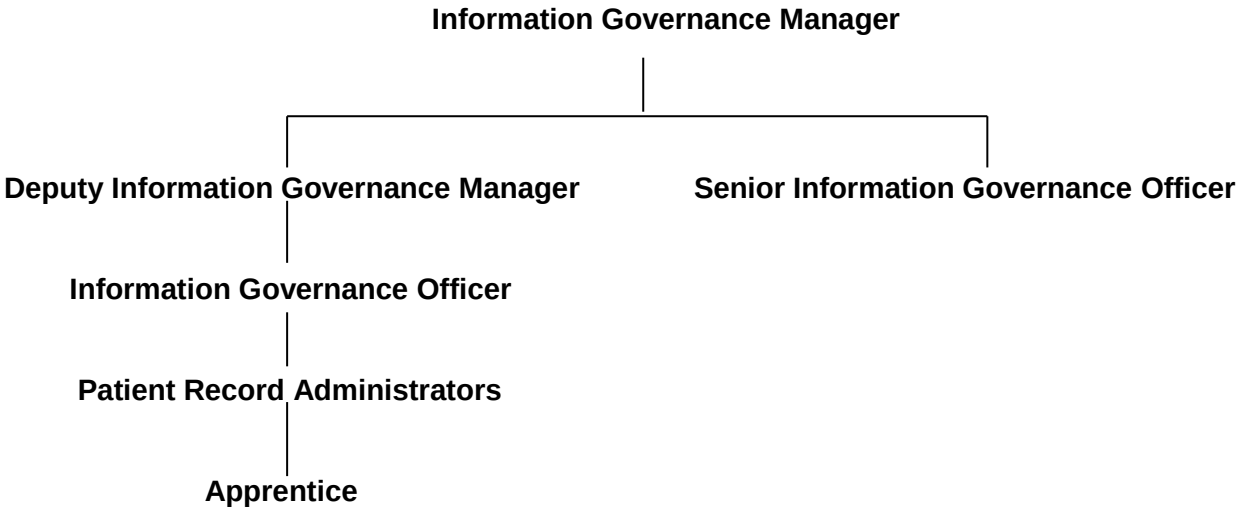
- Medical Director / Caldicott Guardian
- Information Governance Manager
- Deputy Information Governance Manager
- Information Governance Team
- Health Records Manager
- Consultants
- Trust Solicitors
- Patients and members of the public
- Other Healthcare Providers

- Professionals Allied to Medicine
- Administration Services Manager for Radiology
- Health Records Staff
- Medical Secretaries
- Cash Management Team
- Police, Statutory Undertakings, external Solicitors and Insurance Companies
- Other relevant External Organisations including DWP, Local Authorities

4. DIMENSIONS

To supervise 4 WTE staff
The actioning of approximately 2,700 data base access requests each year

5. ORGANISATIONAL CHART



6. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

- To supervise the Information Governance Team ensuring all requests for data are received centrally, recorded and processed in line with Trust / Data Protection Act (DPA) and Access to Health Records Act (AtHRA), adhering to time limits and ensuring any applicable fees are reclaimed.
- To ensure the IG Team handle all requests for Clinical Information by Patients, Police, Statutory Bodies, War Pensions, Department of Social Security and other Hospitals for treatment, are managed and processed in line with statutory requirements and Trust procedures and maintain oversight and monitor requests ensuring only the relevant and authorised information is released, including where this is done without the patient's consent.
- To liaise with the Trust's Caldicott Guardian regarding requests for access to Personally Identifiable Data when it is not possible or appropriate to obtain permission from or for the data subject.
- To monitor IG Team standards and performance and provide monthly activity reports to the Information Governance Manager (IGM) and ensure the Information Governance Team databases, are kept up to date of all actions at all times.
- To ensure accurate photocopying or production of original records so that an exact replica of the that original is produced.
- To ensure accurate records are kept of monetary transactions relating to Subject Access Requests and Medico Legal requests and ensure this is managed efficiently and ensure money is banked with the General Office on the day of receipt.
- To provide advice to data subjects seeking to access their information.
- To arrange viewing of data (ie patient casenotes) as necessary, i.e., booking a room and ensuring a member of the Information Governance Team is available.

- To support the Deputy Information Governance Manager (DIGM) in co-ordinating the completion of the Information Governance Toolkit external assessment including; identifying requirements, evidence and gaps.
- Monitoring incident report activity on a day to day basis for any information security issues and follow up those that require more information for the DIGM to take forward.
- To assist and support the DIGM in raising awareness of IG throughout the Trust by pulling together training material / presentations / handouts / intranet and deliver workshops, corporate induction and ad hoc training as and when necessary.
- To issue and mark paper IG assessments to ensure that staff meet the 80% pass mark and to forward weekly lists of completions to Learning and Development administrator to update ESR, in conjunction with the DIGM.
- Assist the DIGM with Information Governance checks on Research requests that have been to the Ethics Committee ensuring that personal data is processed in line with DPA98 and the Data Protection Principles**.** Also to maintain a database of research requests and identification numbers and escalate any concerns to the IGM.
- Maintain the development of the Information Governance intranet site, ensuring the site provides all relevant information to staff on information governance issues and is maintained and up to date.
- To participate in the Trust's Performance Planning and Review Program

People

- To work effectively with the staff within the Information Governance Team section ensuring the provision of a high quality service.
- To ensure all staff within section undertake their duties in accordance with the Trust's relevant Policies and Procedures and adhere to the legislations set out in the DPA, AHRA, and FOI Acts.
- To work effectively with members of the public, Police, legal representatives and staff in dealing with their queries in respect of access to health records and other information governance issues.
- To ensure ESR is updated on essential training, sickness and PDRs for staff within the Information Governance team.
- To ensure Information Governance Team staff undergo appropriate training for their role.
- To undertake performance, planning and review of staff on a yearly basis.
- To be responsible for the recruitment and selection of Information Governance Team staff in accordance with the Trust's and departmental personnel policies.
- To ensure that the section is adequately staffed at all times.
- To participate in induction of new staff as appropriate.
- To report through the Trusts Accident / Incident reporting system any breaches of security / confidentiality.
- To undertake any other duties as required by the Senior Information Governance Analyst commensurate with the grade

THE TRUST - PURPOSE AND VALUES

We are committed to serving our community by being a high quality specialist Hospital with consultant-led services. We aim to co-ordinate our services with primary and community care, and to develop a limited number as Sub-Regional Referral Centres with appropriate levels of research, development and educational involvement. Where appropriate, and consistent with our services, we may provide services aimed at preventing disease and debilitation.

We aim to make all our services exemplary in both clinical and operational aspects. We will show leadership in identifying healthcare needs to which we can respond and in determining the most cost-effective way of doing so. We will share our knowledge with neighbouring healthcare agencies and professionals.

We recruit competent staff whom we support in maintaining and extending their skills in accordance with the needs of the people we serve. We will pay staff fairly and recognise the whole staff's commitment to meeting the needs of our patients.

We are committed to equal opportunity for all and encourage flexible working arrangements including job sharing.

The Trust is committed to recruiting and supporting a diverse workforce and so we welcome applications from all sections of the community, regardless of age, disability, sex, race, religion, sexual orientation, maternity/pregnancy, marriage/civil partnership or transgender status The Trust expects all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

GENERAL

This is a description of the job as it is now. We periodically examine employees' job descriptions and update them to ensure that they reflect the job as it is then being performed, or to incorporate any changes being proposed. This procedure is conducted by the Manager in consultation with the jobholder. You will, therefore, be expected to participate fully in such discussions. We aim to reach agreement on reasonable changes, but if agreement is not possible, the Trust reserves the right to insist on changes to your job description after consultation with you.

The RD&E is a totally smoke-free Trust. Smoking is not permitted anywhere on Trust property, including all buildings, grounds and car parks. For help to quit call 01392 207462.

As an employee of the Trust, it is a contractual duty that you abide by any relevant code of professional conduct and/or practice applicable to you. A breach of this requirement may result in action being taken against you (in accordance with the Trust's disciplinary policy) up to and including dismissal.

The post holder is expected to comply with Trust Infection Control Policies and conduct him/her at all times in such a manner as to minimise the risk of healthcare associated infection.

Royal Devon and Exeter NHS
NHS Foundation Trust

PERSON SPECIFICATION

POST: **Information Governance Officer**
BAND: **4**

REQUIREMENTS	At Recruitment	At KSF 2nd Gateway	Met	Not Met
QUALIFICATIONS/SPECIAL TRAINING:				
• "O level/GCSE A-C in English Language and Maths	E	E		
• NVQ III Administration / Customer Service or equivalent experience	E	E		
• Medical Terminology	D	E		
• NEBS Introductory Certificate in Management or equivalent experience	D	E		
• ECDL or equivalent experience	E	E		
KNOWLEDGE/SKILLS:				
• Excellent working knowledge of the hospital, specialities and Health Records function	E	E		
• Microsoft Word, Excel and Access	E	E		
• Good keyboard skills	E	E		
• Knowledge / understanding of Data Protection Act 1998	E	E		
• Knowledge / understanding of the Freedom of Information Act 2000	D	E		
• Knowledge / understanding of the Information Governance Toolkit	D	E		
• Excellent communication skills	E	E		
EXPERIENCE:				
• Experience and knowledge of health records documentation, practices and procedures	E	E		
• First line supervision of staff	D	E		
• Demonstrable experience of working to strict policies/ procedures/legislation	E	E		
• Demonstrable ability to work accurately to deadlines	E	E		
• Demonstrable experience of dealing with staff	E	E		
• Presentation skills	D	E		
PERSONAL REQUIREMENTS:				
• Highest Integrity	E			
• Professional approach	E			
• Smart appearance	E			
• Flexible to meet the needs of the service	E			
• Exceptional commitment to detail	E			
• Team Player	E			
• Motivated	E			
• Willingness to learn / research / expand knowledge	E			
OTHER REQUIREMENTS:				
• Current valid driving licence	E			
• Excellent attendance record	E			

*** E**ssential/**D**esirable

HAZARDS :					
Laboratory Specimens Proteinacious Dusts		Clinical contact with patients		Performing Exposure Prone Invasive Procedures	
Blood/Body Fluids		Dusty Environment		VDU Use	x
Radiation		Challenging Behaviour		Manual Handling	
Solvents		Driving		Noise	
Respiratory Sensitisers		Food Handling		Working in Isolation	

(NB. Above Hazards shown is not an exhaustive list)

SR/Y/staff/JD/JD-SIGO

JOB DESCRIPTION

This post has been identified as involving access to vulnerable adults and/or children and in line with Trust policy successful applicants will be required to undertake an Enhanced Disclosure Check.

The Trust is committed to recruiting and supporting a diverse workforce and so we welcome applications from all sections of the community, regardless of age, disability, gender, race, religion or sexual orientation. The Trust expects all staff to behave in a way which recognises and respects this diversity, in line with the appropriate standards.

1. JOB DETAILS

Job Title: **Information Governance Support**

Band: **3**

Reports to: **Senior Information Governance Officer**

Department / Division: **IM&T**

The Information Management & Technology (IMT) Service provides a diverse range of information technology and system services to the Royal Devon and Exeter Foundation NHS Trust and other organisations.

We recognise the Patient in service delivery, system design and prioritisation and work to deliver, support and enable the Corporate and Supporting Strategies.

IMT Services reports to the Medical Director.

2. JOB PURPOSE

- To process all requests for personal identifiable data held by the Trust within the requirements of the Data Protection Act 2018 (DPA), General Data Protection Legislation (GDPR) 2016 and Access to Health Records Act 1990 (AtHRA) legislation.
- To support the Information Governance team with the production and collection of evidence for the annual Data Security and Protection Toolkit submission.

3. DIMENSIONS/KEY WORKING RELATIONS

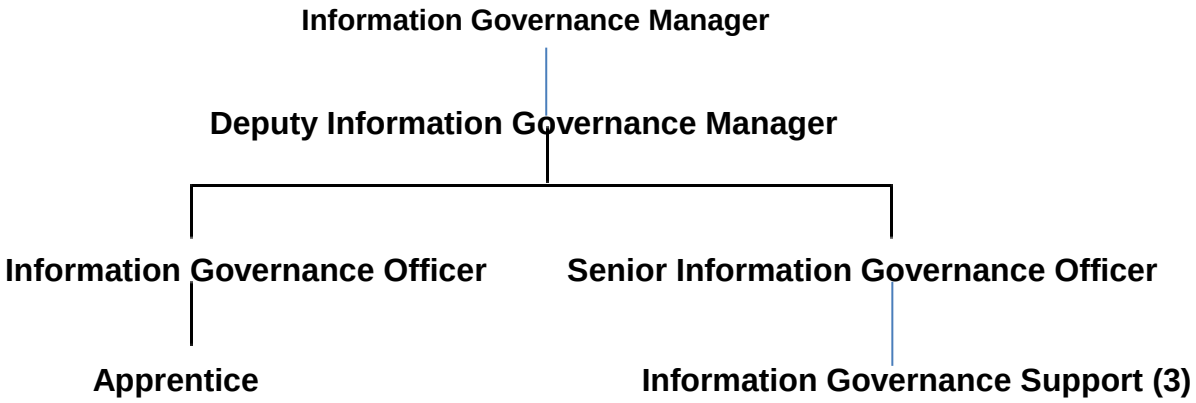
The actioning and processing of approximately 2000 Data Access Requests each year

Key working relationships:

Caldicott Guardian/Medical Director
Head of Application Support & Development
Head of Information Governance
Head of Records Management
Clinical Staff
Trust Solicitor

Solicitors
Admin and clerical staff within the Trust
Patients and relatives
Outside agencies

4. ORGANISATIONAL CHART



5. KEY RESULT AREAS/PRINCIPAL DUTIES AND RESPONSIBILITIES

- To ensure all requests for information under the DPA and AtHRA meet the statutory time frame for completion and escalate timely when there may be exceptions to this.
- To provide regular reports on the completion of requests to the IG Officer/Senior Information Governance Officer.
- To follow the Trust's DPA and AtHRA Procedures upon receipt of an application.
- By careful reading, identify what information is being requested and if held, send out payment request letters.
- To liaise with patients and staff regarding Subject Access Requests
- On receipt/confirmation of payment, the subsequent retrieval of such records by using the Patient Administration System and Trust inventories.
- To process DPA and AtHRA applications by accurately marrying up access requests with the relevant information, i.e. patient's case notes/records and requesting computerised prints from the appropriate system manager/s.
- To accurately identify requested information from records and ensure information is redacted, or withheld, where necessary by applying the Data Protection legislation requirements.
- To obtain the relevant consultants permission to release information to the Requester
- To chase authorisations from Consultants/Departmental Managers to ensure DPA and AtHRA time limits are adhered to in order to comply with the legislation
- The despatch of data to requester, in line with the Trust's Confidentiality and Despatch of Case note Policies.
- To respond to requests from the Police to provide information on patients, escalating as appropriate to line manager, where requests are complex.
- To maintain the relevant Data Access databases and ensure actions are recorded, as and when they occur, i.e. date requested, received, types of notes etc., in order to ensure time limits can be monitored/audited.
- To retrieve and tracer casenotes from the Trust's casenote storage areas as required.
- To ensure all casenotes are traced on PAS and despatched or personally delivered to relevant area as per the Trust policies and procedures.

- To ensure that the security and confidentiality of patient casenotes and information is maintained at all times as per the Trust's Information Governance Policy.
- To accurately open, and receipt all post received by the Information Governance Team.
- To support the Information Governance team by undertaking evidence collection exercises, e.g. Data Mapping and audits, etc. to meet the requirements of the Data Security and Protection Toolkit.
- To check and upload evidence, as required, onto the Information Governance Toolkit.
- To participate in the Trust's Performance Planning and Review programme.
- To escalate complex requests to the Senior Information Governance Officer for advice and guidance.
- To undertake any other duties relating directly to the role or as required by the Head of Information Governance commensurate with the grade

Communication and Relationship Skills:

- To develop and maintain good working relationships and communication links with clinicians and departments at all levels, in order that Subject Access Requests (SAR) responses are provided in the statutory timeframe; this will require a level of skill in gaining co-operation and assistance from all levels of staff concerned.
- To provide and receive routine information requests liaising with patients and staff using tact and persuasive skills
- To liaise with staff across the Trust, developing good working relationships, in order to produce evidence for the IG Toolkit.

Knowledge and Understanding:

- To provide information and advice to the Trust regarding SARs.
- To maintain and update own knowledge of developments DPA.
- Attend regular DPA training and local network groups as appropriate, to ensure the Trust stays abreast of DPA developments.
- To keep updated on the wider Information Governance agenda and the work going on the Trust to support this.

Freedom to Act

- There is a requirement for the post holder to act on own initiative, in line with Trust and national policies, procedures and processes.

Mental Effort

- There is a requirement for sustained concentration in order to produce accurate provision of copied medical records.

Emotional Effort

- The post holder may on occasions be exposed to distressing circumstances in working with patient case notes

Working Conditions:

- The postholder is office based, with a high use of VDU.

Other Responsibilities:

To take part in regular performance appraisal
To undertake any training required in order to maintain competency including mandatory training, i.e. Fire, Manual Handling

To contribute to and work within a safe working environment
The post holder is expected to comply with Trust Infection Control Policies and conduct him/herself at all times in such a manner as to minimise the risk of healthcare associated infection.

THE TRUST - PURPOSE AND VALUES

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GENERAL

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PERSON SPECIFICATION

POST: Information Governance Support
BAND: 3

REQUIREMENTS	At Recruitment	At 2nd KSF Gateway
QUALIFICATIONS/SPECIAL TRAINING:		
• GCSE or equivalent, (including English and Maths at grades A-C)	**E**	**E**
• NVQ Level 3 or equivalent experience		
• ECDL or equivalent computer skills qualification	**E**	**E**
• Hospital Systems; PAS, CDM	**E**	**E**
• IHRIM Technical Certificate	**E**	**E**
	D	**E**
KNOWLEDGE/SKILLS:		
• PC skills – word processing, spreadsheets and email	**E**	**E**
• Proven strong administration skills	**E**	**E**
• Ability to work without supervision	**E**	**E**
• Ability to concentrate for extended periods	**E**	**E**
• Demonstrate exceptional verbal communication skills	**E**	**E**
• Good understanding of the management of casenotes	**E**	**E**
• Familiarity with medical terminology	**D**	**E**
• Knowledge and understanding of Data Protection Act 2018 and General Data Protection Regulation 2016	**E**	**E**
• Knowledge and understanding of the Access to Health Records Act 2000	**E**	**E**
EXPERIENCE:		
• Previous hospital experience	**E**	**E**
• Previous clerical experience in a busy acute environment	**E**	**E**
• Demonstrate ability to work accurately to deadlines	**E**	**E**
• Of dealing with staff at all levels, ie Consultants	**E**	**E**
• Dealing with the general public	**D**	**E**
PERSONAL REQUIREMENTS:		
• Enthusiastic, highly motivated and committed to developing service.	**E**	**E**
• Methodical with exceptional attention to detail and accuracy	**E**	**E**
• Able to work under pressure and manage priorities appropriately	**E**	**E**
• Proven ability to work as a part of a team	**E**	**E**
• Highest Integrity	**E**	**E**
• Professional approach	**E**	**E**
• Empathetic, but able to understand professional boundaries	**E**	**E**
• Positive attitude towards learning and development	**E**	**E**
• Smart appearance	**E**	**E**
• Flexible attitude	**E**	**E**
OTHER REQUIREMENTS		
• Current valid driving licence	**E**	**E**

* **E**ssential/**D**esirable

Hazards within the role, used by Occupational Health for risk assessment					
Laboratory Specimens Proteinacious Dusts		Clinical contact with patients		Performing Exposure Prone Invasive Procedures	
Blood / Body Fluids		Dusty environment		VDU Use	
Radiation		Challenging Behaviour		Manual Handling	
Solvents		Driving		Noise	
Respiratory Sensitisers		Food Handling		Working in isolation	
Handling Cytotoxic Drugs					

Northern Devon Healthcare
NHS Trust

Job Description

1. Job Details	
Job Title:	Healthcare Access to Records Supervisor
Responsible to:	Information Governance Lead
Professionally Responsible to:	Head of Informatics
Grade:	Band 4
Unit:	Information Governance
Location	Northern Devon Healthcare NHS Trust

2. Job Purpose

To support the Information Governance Lead. To be responsible for the supervision of staff and to ensure the smooth and efficient running of the Access to Records department is adhered to at all times

3. Dimensions

The Healthcare Access to Records Department deals with approximately 1,500 requests a year and liaises with other departments within the organisation, solicitors, police, patients, patients relatives, other hospitals and the coroner etc

4. Organisational Chart

Head of Digital Technology
↓
Head of Informatics
↓
Information Governance Lead
↓
Access to Records Supervisor
↓
Access to Records Clerks

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5. Main Tasks/Duties and Areas of Responsibility

- Supervising Access to Records Clerks in all aspects of their work, in line with Trust policies and procedures. Being the expert on hand to deal with any problems that may arise during the shift and provide ongoing support and training.
- Ensuring that all clerks are fully competent in their duties
- Attending meetings and training events as necessary
- Supervising change; in line with trust policies and procedures
- Act on Access to Records issues within set protocols and report any exceptions to the Information Governance Lead
- Receive and respond to telephone calls with regard to patients and staff queries
- Ensure that information about patients is communicated to other departments
- Ensure all minimum data requirements are met
- Assisting in developing guidelines and scripts for staff to use

- Working and maintaining confidentiality,
- Working as part of the Access to Records Team to provide a services to patients and staff
- Contribute towards the planning of changes within the team
- Support the Information Governance Lead in implementing changes to roles in the department.

Security

- Checking authority for the release of confidential information, security and legality of the release of ultra sensitive information, e.g. child protection issues

Health and Safety/Policies

- Propose and implement local changes to documentation and policies.
- Demonstrate a basic knowledge of health and safety practices.
- Take all reasonable care of the safety of yourself and others whilst at work, including responsibilities outlined in the Health and Safety at Work Act. Compliance with codes of practice, Trust Policies and Procedures, Hygiene Regulations and Infection Control.
- Report any problems immediately to your Manager for action.

General

- Maintain good personal hygiene and a smart appearance.
- Maintaining the integrity and reputation of the Department by working positively towards an effective and harmonious team.
- Attend meetings and training sessions as seen necessary to maintain safe and up to date skills and knowledge to carry out your duties.
- Maintain confidentiality of all relevant data relating to patients, staff and certain service information.
- You may be expected to work as part of the wider Information Governance team providing an integrated and flexible service and as such may sometimes be required to undertake duties within other areas of the Department should the needs of the service demand it.

The duties of this post are subject to review and amendment as necessary.
This Job Description is a guide only to the duties and responsibilities attached to the post. Similarly the main tasks are indicative only of the type of duties undertaken, and are not exhaustive. The existence of a Job Description does not inhibit flexible working.

Infection Control

- Ensure safe practice to minimize the risks of infection to patients and staff in accordance with national and Trust policy, in particular to be aware of responsibilities as listed in the Infection Control Operational Policy.

6. Communication and Working Relationships

- Medical Secretaries
- Doctors and other Medical staff
- Porters and Post/Delivery staff
- Police
- Solicitors
- Patients
- Patients Relatives

- Litigation Department
- Insurance Companies
- Benefits Agencies

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Northern Devon Healthcare
NHS Trust

Person Profile

Job Title:	Access to Records Supervisor
Grade:	Band 4
Department:	Information Governance

Criteria Required	Essential
Qualifications & Training	GCSE/O Level equivalent in English and Math's Knowledge of related systems to NVQ 3 in business/admin studies based role, or equivalent experience of at least 3 years Knowledge of the Patient Administration System(TrakCare) ECDL or CLAIT equivalent IT qualification Good verbal communication skills and team working.
Specific Knowledge & Skills	Ability to produce and maintain spreadsheets and reports Knowledge of disclosure of information in accordance with current legislation Ability to manage E-mail and Numerically competent Excellent communication and customer service skills Ability to priorities own workload and to met deadlines Ability to work without supervision
Special Experience	Previous experience in a large and/or busy office environment Significant experience in creating and maintaining spreadsheets Good verbal communication skills and team working.
Physical Skills & Effort	Job requires reasonable standard of fitness due to pulling and locating case notes. Sustained periods of time in front of PC and standing when photocopying Advanced keyboard skills for data entry
Emotional Effort	Daily ability to communicate effectively with individuals, dealing with the general public A flexible approach to work with a pleasant personality. Weekly exposure to distressing or emotional circumstances when dealing with requests and reading notes when copying

	Occasional exposure to verbal aggression from patients.
Mental Effort	Ability to work under pressure and to very strict deadlines. Be able to prioritise own workloads and ensure quality of work meets the high standards set out in the Trust's policies Ability to adapt and change workload Remain calm and polite to customers and staff Must be flexible and able to multitask Requirement for long periods of concentration
Requirements due to working environment	Ability to use VDU equipment periods in accordance with Health and Safety Regulations

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Job Description

1. Job Details	
Job Title:	Healthcare Access to Records Officer
Responsible to:	Acting Information Governance Lead
Professionally Responsible to:	Digital Services
Grade:	Band 3
Unit:	Information Governance - Access to Records team
Location	Northern Devon Healthcare NHS Trust

2. Job Purpose

- To be responsible for access to records function, within the department. Manage and prioritise own workload
- To play a key role in ensuring the smooth running of the Access to Records office
- Receiving and logging requests for information from Healthcare Records case notes, making judgments on validity of request in accordance with current legislation
- Investigate and track notes where necessary
- Ensuring payment is received in accordance with the Trusts policies and procedures

3. Dimensions

The Healthcare Access to Records Department deals with approximately 1,500 requests a year and liaises with other departments within the organisation, solicitors, police, patients, patients relatives, other hospitals and the coroner etc

4. Organisational Chart

Head of Digital Technology
↓
Head of Information Management
↓
Acting Information Governance Lead
↓
Healthcare Access to Records Supervisor
↓
Healthcare Access to Records Officers

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5. Main Tasks/Duties and Areas of Responsibility

- Be responsible for disclosure of information in accordance with current legislation
- To enter all applications onto an excel spreadsheet when they are received either via the post, telephone, or email
- To update the excel spread sheet at each stage of the process so as the client is kept up to date
- To receive information from Radiology with regard to x ray numbers
- Applications are received from the Healthcare Professionals from hospital both in the UK and Abroad requesting information about patients being treated in their hospitals,

which includes the police, all staff, the Litigation department, Solicitors, Insurance companies, patients, Patient's relatives and the Benefit Agency.

- To prioritise workload according to need either clinical or time constraints
- To liaise with Healthcare Professionals, seeking advice on procedures for access, with PALS on behalf of members of the public, with members of the legal profession, with the police, wishing a very tight turnaround of information and with any other hospital who need information quickly as patient has been taken into their hospital urgently
- To locate and electronically track patient records and all information from departments that does not hold their notes in the main NDHT case notes. To request that these departments either send copies or the original which will be copied and returned
- To request copies of x-rays only
- To photocopy only relevant parts of the patients record or the complete set if requested
- To receive and log all extra records
- To send completed photocopied notes to all Consultants for signature and to follow up if not returned by the time given, as time constraints apply for completion
- To complete a covering letter and send with the photocopied notes to applicant
- To close date on log with recorded delivery number recorded
- To record delivery all clinical information that is sent out
- To file paperwork for future reference
- To assist with the induction, supervision and training of new staff to the department
- To supervise patients wishing to view their own notes rather than have copies
- To organise the workload to priority for other members of the Access to Records Team
- To give statements to the police in the event of notes required in criminal proceedings
- To carry out basic maintenance duties on office equipment.
- To be fully conversant with Health and Safety procedures and have full knowledge of how to act effectively in emergency situations that occur in the hospital or community setting
- Any such other duties as required by the Healthcare Records Manager

Security

- Checking authority for the release of confidential information, security and legality of the release of ultra sensitive information, e.g. child protection issues

Health and Safety/Policies

- Propose and implement local changes to documentation and policies.
- Demonstrate a basic knowledge of health and safety practices.
- Take all reasonable care of the safety of yourself and others whilst at work, including responsibilities outlined in the Health and Safety at Work Act. Compliance with codes of practice, Trust Policies and Procedures, Hygiene Regulations and Infection Control.
- Report any problems immediately to your Manager for action.

General

- Maintain good personal hygiene and a smart appearance.
- Maintaining the integrity and reputation of the Department by working positively

towards an effective and harmonious team.

- Attend meetings and training sessions as seen necessary to maintain safe and up to date skills and knowledge to carry out your duties.
- Maintain confidentiality of all relevant data relating to patients, staff and certain service information.
- You may be expected to work as part of the wider Healthcare Records team providing an integrated and flexible service and as such may sometimes be required to undertake duties within other areas of the Department should the needs of the service demand it.

.

The duties of this post are subject to review and amendment as necessary.
This Job Description is a guide only to the duties and responsibilities attached to the post. Similarly the main tasks are indicative only of the type of duties undertaken, and are not exhaustive. The existence of a Job Description does not inhibit flexible working.

Infection Control

- Ensure safe practice to minimize the risks of infection to patients and staff in accordance with national and Trust policy, in particular to be aware of responsibilities as listed in the Infection Control Operational Policy.

6. Communication and Working Relationships

- Medical Secretaries
- Doctors and other Medical staff
- Porters and Post/Delivery staff
- Police
- Solicitors
- Patients
- Patients Relatives
- Litigation Department
- Insurance Companies
- Benefits Agencies

.

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Person Profile

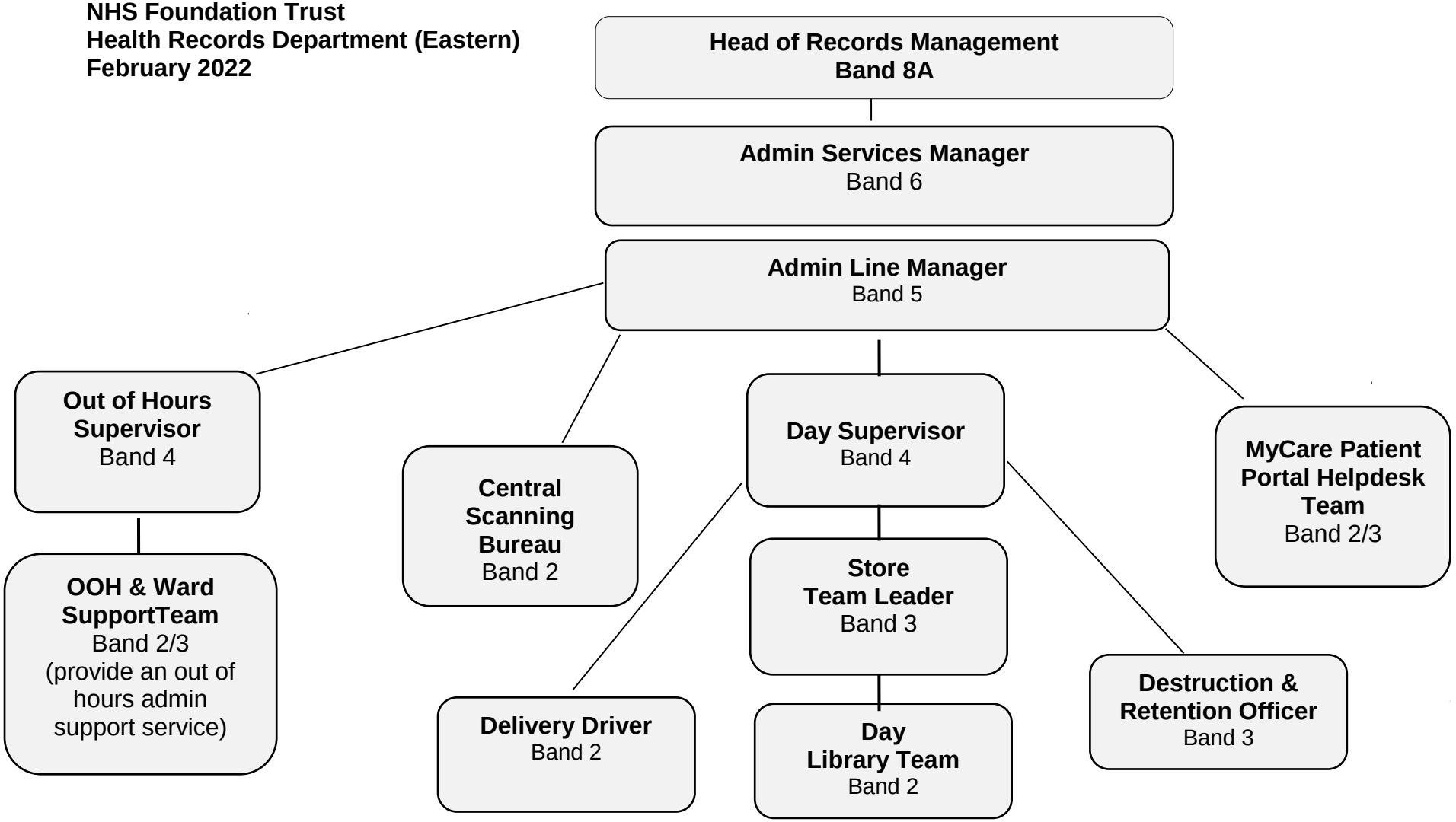
Job Title:	Healthcare Access to Records Officer
Grade:	Band 3
Department:	Information Governance - Access to Records team

Criteria Required	Essential
Qualifications & Training	GCSE/O Level equivalent in English and Math's Knowledge of related systems to NVQ 3 in business/admin studies based role, or equivalent experience of at least 3 years Knowledge of the Patient Administration System(TrakCare) ECDL or CLAIT equivalent IT qualification Good verbal communication skills and team working.
Specific Knowledge & Skills	Ability to produce and maintain spreadsheets and reports Knowledge of disclosure of information in accordance with current legislation Ability to manage E-mail and Numerically competent Excellent communication and customer service skills Ability to priorities own workload and to met deadlines Ability to work without supervision
Special Experience	Previous experience in a large and/or busy office environment Significant experience in creating and maintaining spreadsheets Good verbal communication skills and team working.
Physical Skills & Effort	Job requires reasonable standard of fitness due to pulling and locating case notes. Sustained periods of time in front of PC and standing when photocopying Advanced keyboard skills for data entry
Emotional Effort	Daily ability to communicate effectively with individuals, dealing with the general public A flexible approach to work with a pleasant personality. Weekly exposure to distressing or emotional

	circumstances when dealing with requests and reading notes when copying Occasional exposure to verbal aggression from patients.
Mental Effort	Ability to work under pressure and to very strict deadlines. Be able to prioritise own workloads and ensure quality of work meets the high standards set out in the Trust's policies Ability to adapt and change workload Remain calm and polite to customers and staff Must be flexible and able to multitask Requirement for long periods of concentration
Requirements due to working environment	Ability to use VDU equipment periods in accordance with Health and Safety Regulations

Royal Devon and Exeter NHS
NHS Foundation Trust

Royal Devon University Healthcare
NHS Foundation Trust
Health Records Department (Eastern)
February 2022



Royal Devon University Healthcare
NHS Foundation Trust

Digital Healthcare Service Departmental Structure (Northern Services)