Appraisal Report Legacy Functions, Activities and Records Evaluation Template

Appraisal Report

Legacy Functions, activities and records evaluation for Capital and Coast District Health Board

File/Document ID	APP2017/0003
Agency	Capital & Coast District Health Board (CCDHB)
Contact Name and Details	[Name removed]
Date	13 June 2017

Purpose
To support effective and efficient records management for CCDHB, and to mitigate current risk as part of the organisational risk management framework.
Scope
This appraisal covers an estimated 860 non-current patient records created in the period 1921 to 1946. These are the summary details of individual patient hospital visits, and do not include the summary records or registers from this same period.
Format
These records are in paper format only.

Function/Activity Information/Collection

Context, predecessor agencies, management environment:

This group of records were created in the period 1921 – 1946 when Capital & Coast District Health Board was known as Wellington Hospital. At that time there were no specific legislative requirements for the control of patient records or of health information in general. The management of these records would have been greatly affected by the many changes in the accommodation for storage of medical records at Wellington Hospital in the period from 1930 – 1954. The main problem for the governing Boards of the time was the accommodation of patients, as the demands on hospital services grew rapidly during and after the second world war. The first 'Medical Records Department' in Wellington Hospital was set up in 1954.
From the outset, space has remained at a premium on the Newtown campus, and Wellington Hospital and its successor agencies began using commercial offsite storage facilities to manage the overflow of patient records in 1995. Since that time, back numbers of files have been stored offsite and retrieved as required.

The management environment in which the New Zealand health systems operated from 1983 to 2001 is an important factor to understand the recordkeeping of the time, and the very basic nature of the systems. Changes in that period were commercially focussed and functions such as recordkeeping were not well resourced:

- 1983 – 1993 14 Area Health Boards were formed
- 1993 – 4 Regional Health Authorities were established, and Area Health Board became Crown Health Enterprises (CHE's), operating as not-for-profit companies
- 2001 – 21 District Health Boards were formed

Legislative direction:

It is also important to note that in 1997, the Ministry of Health issued a directive that CHEs could dispose of medical records 10 years or over if inactive, and accordingly several CHEs did carry out a destruction process in line with this policy. Capital & Coast did not destroy medical records under this directive, although the cost of storage would have made this seem an attractive option.

Recordkeeping systems:

Earlier recordkeeping systems identified records with a six digit number, and records appear to have been filed in number order.
The advent to the NHI Index in the late 1980's transformed the management of the individual patient health record, as did the change to the electronic capture of this information in patient management systems which began to develop at the same time.

Recordkeeping issues:

In 1999 Capital & Coast tendered for the provision of offsite records storage, and a new provider was contracted. There were two issues with the transition to the new provider, which have resulted in CCDHB having very limited information on the content of the boxes containing the oldest patient records.

- A large number of the older cohort of files were not transferred in number order, but randomly packed by the provider in unlabelled boxes.
- The database /finding tool was not secured in the original contract, and it required a court process to have this released. Once received, the data was found to be inadequate, and of no use for searching the contents of the boxes.

The current situation is that we have 11,500 boxes of patient records which may contain a small number of records which fall into the 'Historical Records' classes 8.1 and 8.2 in DA 262, but there is no finding tool to search the contents. The only way to do this would be to open all 11,500 boxes and examine each of 575,000 records, which we estimated would cost $13,000 (1FTE x 5 months).

Methodology

- **Sampling**

  40 boxes from 11,500 boxes of records which have passed their retention date were selected for examination. 2,000 records were examined closely by CCDHB medical records staff familiar with the layout and content of the older patient records. Only 3 records were pre 1946, leading to the conclusion that there may be approximately 860 pre 1946 records in the 11,500 boxes.

- **Risk assessment**

  Based on the findings from sampling, CCDHB assessed the risk of retention and disposal of these records using Archives NZ **risk matrix table** below. The risk assessment report is attached as Appendix 1.

IMPACT	**5-Severe**	**15**	**19**	**22**	**24**	**25**
	4-Significant	**10**	**14**	**18**	**21**	**23**
	3-Moderate	**6**	**9**	**13**	**17**	**20**
	2-Minor	**3**	**5**	**8**	**12**	**16**
	1-Minimal	**1**	**2**	**4**	**7**	**11**
		1-Almost Never	**2-Possible but Unlikely**	**3-Possible**	**4-Highly Probable**	**5-Almost Certain**
LIKELIHOOD						

Appraisal statement and District Health Boards' General Disposal Authority (DA262)

Archives New Zealand's guidance including the appraisal statement and DA262 were referred to, for the assessment of the value of the records.

Consultation

Internal: Consultation was carried out as follows: Executive Director Quality Improvement and Patient Safety; General Manager Corporate Services; Health Information and Records Committee; CCDHB Legal Counsel. There were no adverse comments on the Appraisal Report from internal consultation.

External: Those consulted were the Ministry of Health, [details removed], and the University of Otago Wellington, [details removed].

Both parties were in agreement with the risk based approach being taken to this Appraisal by CCDHB, noting that the valuable information is in the registers and indexes which control these patient records and these registers will be retained as public archives. There was also agreement that the risk of loss of data would be minimal, and that there is greater risk associated with over-retention of the records.

Class or class grouping

Description

The records covered by this appraisal are patient records created between 1921 and 1946 (DA262 Class 8.2). The patient records are registration information but they are not registers as such.

The information generally consists of dates of visits, or of admission and discharge and summarised demographic information. In a very few cases, there is a short statement of the present medical condition at the time of admission, but details of treatment or outcomes are not found on these records.

Value Statement

A decision regarding a disposal action for the records created between 1921 and 1946 was not made at the time the District Health Board's General Disposal Authority (DA262) was approved. This means that DA262 does not prescribe a specific disposal action covering records created between 1921 and 1946.

However, the DA262 does allow for records to be sentenced 'in some instances' against the disposal schedule (as noted in the appraisal report of DA262, page 4). This can be applied to these records created after 1920. This is relevant to this appraisal as the function of clinical care at that time is little different to the current function as well as the way the patient information is managed, e.g. patient registers and indexes regardless of whether digital or paper.

To make it a more robust disposal decision, six criteria of Archives New Zealand Appraisal Statement were also tested to assess the archival value of these records as below:

Criteria 1. Business value

- These records no longer have business value as a patient record; nor do they contain information required for the clinical care of current patients of the DHB
- There is no evidence of clinical decision-making in records of this type and age; they contain scant demographic information; visit dates; and a brief statement of the presenting problem
- These records contain no information that would inform the development of new services

Criteria 2. Accountability

- These records served their purpose in documenting hospital visits at the time, but are no longer useful accountability documents.

Criteria 3. Rights and entitlements

- These individual patient records would be of minimal value in providing evidence of rights and entitlements at the time. Information of this kind is more likely to be found in summary and control records of the time, recommended for retention as public archives in DA262 Classes 3.1 – 3.10

Criteria 4. Legitimacy of Authority

- Not relevant in this case

Criteria 5. Treaty of Waitangi

- No evidential value

Criteria 6. Knowledge

- These records would not contribute to the body of knowledge (note above, criteria 3, the potential contribution of the summary and control records)

CCDHB has also conducted a risk analysis. Based on the analysis, risks of over-retention of these records far outweigh risks of destroying these records (See Appendix 1).

Consideration of the extent of value

In summary, any information in the pre1946 patient records would be incomplete, and there are other datasets, being summary and control registers and indexes of hospital activity at the time. Most of these summary records were transferred to Archives New Zealand and more of the same category of records will be transferred from CCDHB over time. Some are still in use as finding tools in CCDHB. These resources provide much more meaningful context than do the individual patient records.

Therefore, these records are recommended for destruction.

Disposal recommendation
Destroy CCDHB patient records created between 1921 and 1946.
Access Recommendations
Not applicable
Appendices
Appendix 1: Risk Assessment

APPENDIX 1 – Risk Assessment

Capital & Coast District Health Board

Appraisal of Patient Records created prior to 1920 and prior to 1946
Risk Assessment

1. Risks to Capital & Coast District Health Board (CCDHB)

The purpose of this paper is to provide a risk assessment on the proposal to recommend destruction of a group of patient records held by CCDHB. In the course of implementing a disposal programme of a large number of over-retention records, associated risks and issues have been identified as follows.

1.1 Reasons behind over-retention of patient files

- A legacy of unstructured information attributable to the difficulty of recordkeeping in the health environment prior to the advent of the National Health Index (NHI) in the late 1980's, subsequently enabling electronic capture of patient records.
- the lack of direction for recordkeeping for District Health Boards prior to the governance of the Health Regulations (Retention of Health Information) 1996, Public Records Act 2005, and General Disposal Authority for DHBs 2006 (DA 262)
- the professional or personal preference of many clinicians to retain patient information for ongoing reference, health related research, etc.
- the cost of storage and/or destruction due to the size of the legacy collection
- a general sensitivity around the destruction of personal information

1.2 Cost of over-retention

- The cohort of 575,000 (est.) patient files that have been over-retained are stored in commercial storage in 11,500 boxes at a cost of $30,000 per annum
- There are significant cost savings in the disposal of these items, taking into account one-off destruction costs
- The management and contextual issues referred to above have stood in the way of more timely action to dispose of these records, and these unnecessary costs are no longer sustainable for CCDHB

1.3 Information discovery and integrity

- Over-retention of the records that are unstructured and not searchable could lead to a breach of privacy in the future, or accidental loss, as the system is currently cluttered by records which should have been destroyed earlier.

In summary, we contend that there are serious risks if this group of 575,000 patient records continues to be over-retained, and these will impact CCDHB's ability to:

- Attain legislative compliance
- Ensure business efficiency and cost savings

Maintain confidence and trust in its reputation

1.4 Mitigation

The mitigation plan for this risk is the implementation of a destruction programme to dispose of those patient files that have passed their retention date. This programme began in 2015, and is

planned to run for a further three years to complete the disposal of the legacy files that have been over-retained. From there, a regular destruction programme will continue to ensure compliance.

2. Risk Assessment

2.1 Risk Rating - Impact

Using the **risk matrix table** provided, CCDHB assigns an impact score of 3 - moderate

- Extra costs would exceed budgets and impact on core business
- Key outcomes (eg compliance) would be affected

IMPACT	**5-Severe**	**15**	**19**	**22**	**24**	**25**
	4-Significant	**10**	**14**	**18**	**21**	**23**
	3-Moderate	**6**	**9**	**13**	**17**	**20**
	2-Minor	**3**	**5**	**8**	**12**	**16**
	1-Minimal	**1**	**2**	**4**	**7**	**11**
		1-Almost Never	**2-Possible but Unlikely**	**3-Possible**	**4-Highly Probable**	**5-Almost Certain**
LIKELIHOOD						

We have applied the Archives NZ Appraisal criteria to assess the intrinsic value of the 860 (approx.) records covered by DA262.

Evidential value of the 860 records of pre 1946 patients has diminished over time, as has their business value. There are also registers and indexes which control these patient records. These registers will be retained as public archives.

In summary, the value of this group of records supposed to be in the cohort of 575,000 records sentenced for destruction is considered to be very low.

2.2 Risk Rating - Likelihood

Because there is a 10% chance that the risk will occur over the next 12-18 months, it is given a likelihood score of 1 – almost never

Using the **risk matrix table,** the risk score assigned to this risk is 1.

2.3 Final Risk Rating – 6