Cumbria Partnership
NHS Foundation Trust

Policy Title: Health Records Policy (CPFT)

Reference	POL/002/008
Version	3.0
Date Ratified	16/11/2018
Next Review Date	Dec 2021
Accountable Director	Michael Smillie, Director of Finance, Digital & Estates
Policy Author	Helen Charnley, Health Records Manager

Please note that the Intranet / internet Policy web page version of this document is the only version that is maintained.

Any printed copies or copies held on any other web page should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Policy On A Page

SUMMARY & AIM

The Health Records Management Policy sets out procedures and standards required to manage health records, regardless of the format, throughout the records lifecycle.

This policy and the Standard Operating Procedures which are linked to this policy provide clearly defined procedures for the creation, use, management, archiving, transportation and disposal of all clinical records regardless of format.

TARGET AUDIENCE:

- All staff at all levels of the organisation who handle or input into health records

TRAINING:

- Training in Health Records Keeping Standards, missing records, and creating and tracking of paper health records available from the Health Records Department

KEY REQUIREMENTS

Health Records must be created, used, maintained, retained, transported and disposed of in line with this policy and the associated procedures.

TABLE OF CONTENTS

1. INTRODUCTION

This policy provides the basis for good practice in the management of health records from the point of creation to permanent disposal.

Health records are a valuable resource because of the information they contain. High quality information supports and underpins good quality care and business practices. Information is most valuable when it is accurate, up to date and accessible when needed. An effective health records management service ensures that information across the whole range of the lifecycle is managed properly in order to support;

- Patient care
- Day to day business
- Evidence based clinical practice
- Sound administrative and managerial decision making
- The need to meet legal requirements
- Clinical and business audits
- Improvements in clinical effectiveness
- Patient choice and control over treatment and services

The health records lifecycle refers to the policies, processes, practices, services and tools used by an organisation to manage its information through every stage of its existence, from the point of creation to the act of permanent disposal or destruction. The health records lifecycle principles apply to information captured and held on paper or any other physical forms including electronic, microfilm, audio and video. The key components are record creation, maintenance and use (including the tracking of health record movements), access and disclosure; closure and transfer; archiving, appraisal, disposal and destruction.

This policy sets out the principles of health records management and the standards which the Trust should adhere in order to ensure compliance with relevant legislation, regulations and standards, and provide a basis for accountability and responsibility for information and records management.

2. PURPOSE

All health records created in the course of the business of the Trust are public records under the Public Records Act 1958 and 1967. The Trust must therefore take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice 2016 and in particular;

- The Public Records Act 1958;
- The Public Records Act 1967;
- The Data Protection Bill 2018;
- The Freedom of Information Act 2000;
- The Common Law of Confidentiality; and

- The NHS Confidentiality Code of Practice 2003

And any new legislation affecting health records management as it arises.

The Health Records Management Policy aims to ensure compliance with these legal and professional obligations by ensuring that all information, whatever the medium, is appropriately managed and available to;

- Provide a framework to ensure that health records are authentic, reliable, are usable and have integrity in line with the Records Management Code of Practice for Health and Social Care 2016.
- Identify and manage the risks associated with health records in all media: electronic, paper, digital images, scanned records, audio and video.
- Meet legal requirements under the Access to Health Records legislation and the Data Protection Bill 2018.
- Ensure that the security and confidentiality of the Trust's records are maintained.

3. HEALTH RECORDS POLICY:

3.1 Record Creation

The guidance for creating health records is set out in the **Standard Operating Procedure for Health Records Keeping Standards. (Standard Operating Procedure for Paper Health Record Keeping Standards (POL/002/008/023) and Electronic Health Records Keeping Standards (POL002/008/002).**

Records will be created and used only for the purpose for which they are intended. Records created by the Trust will be arranged in an accredited record-keeping system if created electronically and in structured paper files that enables the Trust to obtain the maximum benefit from quick and easy retrieval of information.

When creating information in the first instance, the following should be adhered to, the information must be;

- **Available when needed –** To enable a reconstruction of activities or events that have taken place.
- **Accessible to all authorised members of staff who require access in order to enable them to carry out their day to day work.**
- **Interpretable, clear and concise –** The context of the information must be clear and be able to be interpreted appropriately i.e. who created or added to the record and when this occurred.
- **Trusted, accurate and relevant –** The authenticity must be demonstrable and the content relevant.
- **Secure –** The information must be secure from unauthorized or inadvertent alteration, erasure while in use, storage or transfer or transportation both within and outside the Trust.
- **Access and disclosure –** This must be properly controlled and audit trails used to track all use and changes. The information must be held in a robust

format which remains readable for as long as the information is required or retained.

- **Scanning –** When scanning documents into an electronic records management system, the **Standard Operating Procedure for the Scanning of Health Records** should be followed to ensure compliance with the 'Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically' (BIP 0008) or BS 10008.

Each record will be protectively marked with 'NHS Confidential' to identify the level of confidentiality the record requires. This should be recorded on the front cover and on each sheet contained within a paper record and the any records printed from an electronic system.

Alerts relating to individual patients must be recorded in both the paper and electronic record. Details of managing the recording of alerts are set out in the **Standard Operating Procedure for Health Records Keeping Standards. (Standard Operating Procedure for Paper Health Record Keeping Standards (POL/002/008/023) and Electronic Health Records Keeping Standards (POL002/008/002).**

As part of the record creation, care must be taken to ensure that duplicate or confused records are not created.

All records should be created in line with Health Records Keeping Standards, these are a set of national and local guidelines which should be adhered to and govern how a health records is written and managed. Further information can be found in **Standard Operating Procedure for Health Records Keeping Standards. (Standard Operating Procedure for Paper Health Record Keeping Standards (POL/002/008/023) and Electronic Health Records Keeping Standards (POL002/008/002).**

3.2 Records Use and Maintenance

All staff who input into a health record should follow the Trust's Health Records Keeping Standards set out in **Standard Operating Procedure for Health Records Keeping Standards. (Standard Operating Procedure for Paper Health Record Keeping Standards (POL/002/008/023) and Electronic Health Records Keeping Standards (POL002/008/002).**

All information must be used consistently, only for the intentions for which it was intended. It is not acceptable for staff to access patient health records for an individual employee's gain or purpose, or for personal reasons. If in doubt employees should seek guidance from the Head of Information Governance, SIRO or Health Records Manager. Further guidance relating to information governance breaches can be found within the Information Governance Policy.

All information needs to be maintainable throughout time. The qualities of availability, accessibility, interpretation and trustworthiness must be maintained for

as long as the information is required, perhaps permanently, despite changes in format.

For electronic records, maintenance must include backup and migration to new platforms to ensure continued access to readable information.

The record tracking system (Trac-It) will record all paper health record movements. Tracking of health records will be undertaken in accordance with the **Standard Operating Procedure on the Retrieval and Tracking of Health Records (POL/002/008/004).**

All health records should be transported both internally and externally in accordance with the **Standard Operating Procedure on the Transport of Health Records (POL/002/008/020).**

All records, irrespective of the medium, will be stored in a manner that is safe, clean and tidy, secure from unauthorized access and stored in an environment which meets health, safety and fire regulations.

The restricting of any health records should be undertaken in line with the **Standard Operating Procedure Restricting Health Records in Electronic Patient Record systems (POL/002/008/026).**

Health records should be closed as soon as they have ceased to be in active use other than for reference purposes. Paper health records which are no longer required for active patient care should be sent for storage at the Health Records Department, Carleton Clinic, Carlisle. The Health Records Department will follow guidance on archiving is set out in the **Standard Operating Procedure on the Retention and Archiving of Health Records(POL/002/008/009)** to ensure that all records are archived appropriately.

Missing and unavailable health records must be reported through the Ulysses Incident system and reported to the Health Records Department. Further guidance is available in the **Standard Operating Procedure on Missing and Unavailable Records (POL/002/008/005).**

When there is a need to move paper health records from one location to another within the Trust due to office of clinic moves, the Health Records Manager must be involved in the planning from an early stage to ensure the transfer is arranged in a way that is safe, secure and efficient. Further guidance is contained in the **Standard Operating Procedure on Managing Health Records when Moving Offices (POL/002/008/021).**

Health Records relating to transgendered patients should be managed in line with the **Standard Operating Procedure Managing Health Records of Transgendered Patients (POL/002/008/027).**

3.3 Record Retention

All health records should be 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.

The Trust has adopted the retention periods set out in **Appendix 3** of the **Records Management Code of Practice for Health and Social Care 2016** unless there is a specific reason for this retention period being extended.

Detailed guidance on the archiving and retention of records is set out in the **Standard Operating Procedure on the Retention and Archiving of Health Records (POL/002/008/009).**

The exception to the above relates to the permanent preservation and retention of individual health records beyond the minimum retention period, which is the responsibility of the individual clinician in charge of the care of the patient. The decision will be based on a review of the records to determine whether they are to be selected for permanent preservation or destroyed. In this case, each health records will be clearly marked to identify that they are for permanent preservation.

3.4 Record Appraisal, Disposal and Destruction

Disposal is the term used to cover the final action taken on health records. This will be either destruction or transfer to archival storage.

When a health record comes to the end of its retention period the record will be appraised for disposal in line with the **Standard Operating Procedure Appraisal, Disposal and Destruction of Health Records (POL/002/008/014).**

All health records at the end of their retention period will be appraised by the health records team for either permanent preservation or disposal.

Records identified for permanent preservation will be transferred to the County Archives Service. An inventory of all records passed to the County Archives will be retained indefinitely by the Trust.

Health Records which meet the criteria for destruction will be disposes of in a manner which ensures records cannot be retrieved or re-created. An inventory of all records identified and sent for destruction will be retained indefinitely by the Trust.

The destruction of paper health records will be carried out by an approved contractor who will provide assurances that the records are handled in a safe and secure manner and the confidentiality of the information held within the paper record up to and following destruction is maintained. The approved contractor will provide a certificate of destruction which will be retained indefinitely by the Trust.

4. TRAINING AND SUPPORT

Training in Health Records Keeping Standards, missing records, and creating and tracking of paper health records is available from the Health Records Department.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Health Records Keeping Standards	Audit of Health Records Keeping Standards	Health Records Manager	Information Governance Performance Group	Quarterly
Scanning of health records	Audit of scanning uploaded into Electronic Patient Record.	Health Records Manager	Information Governance Performance Group	Quarterly
Missing and Unavailable Health Records	Report on missing and unavailable records	Health Records Manager	Information Governance Performance Group	Quarterly

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the *name of relevant committee* minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

Academy of Medical Royal Colleges – A Clinician's Guide to Records Standards: Part 2
https://www.rcoa.ac.uk/sites/default/files/FPM-clinicians-guide2.pdf

HSCIC: Checklist guidance for reporting, managing and investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation)
https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf

Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (BIP 0008)
http://www.thecabinetoffice.co.uk/page28.html

Records Management Code of Practice for Health and Social Care 2016
https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-

Caldicott Principles 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

Information Commissioner's Guide to the General Data Protection Regulation (GDPR)
https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/

Data Protection Act 1998
https://www.legislation.gov.uk/ukpga/1998/29/contents

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

Confidentiality: NHS Code of Practice
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf

7. ASSOCIATED DOCUMENTATION:

Health Records Standard Operating Procedures.

SOP: Transition from Paper Health Records to Electronic	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx
SOP: Paper Health Record Keeping Standards	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Missing and Unavailable Records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx
SOP: Retrieval and Tracking of Health Records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItemsaspx.
SOP: Transportation of Health Records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Managing Health Records when Moving Offices	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Electronic Health Record Keeping Standards	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Requesting Paper Health Records for Audits	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.

SOP: Retention and Archiving of Health records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Appraisal, Disposal and Destruction of Records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Scanning and Uploading of Health Records	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Agile working	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Multi-disciplinary Record Keeping Audit	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Restricting Health Records in Electronic Patient Record (EPR) systems	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Managing Health Records of Transgendered Patients	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
SOP: Managing S flagged records on PDS	http://cptportal.cumbria.nhs.uk/SiteDirectory/eHealthCumbria/Health-Records/Procedures/Forms/AllItems.aspx.
Information Governance Policy	https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/IGStrategicFramework_POL-002-007.pdf

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

8.2 Executive Director Responsibilities – Director of Finance

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

8.3 Managers Responsibilities:

Managers are responsible for ensuring that they and their staff are aware of this policy and any associated procedures and what is required of them in relation to this policy. All managers are responsible for ensuring that staff receive the appropriate training in order to fulfil their duties relating to the creation, use, maintenance and disposal of health records.

8.4 Staff Responsibilities:

Staff are, under the Public Records Act 1958, responsible for any records that they create or use in the course of their duties. In accordance with this all staff should ensure that they are familiar with this procedure and know where to locate it. All staff should comply with the practices identified in this procedure and attend any training which is necessary for the implementation of practices associated with this document.

8.5 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

9. DEFINITION OF TERMS USED

Health Record

The Data Protection Act 2018 defines a health record as:

A record which consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care of treatment of the individual to whom the data relates.' Part 7(12) p122.

Health data is personal data related to the physical or mental health of a natural person, including the provision of health care services, which reveal information about his or her health status;

'Personal data' means any information relating to an identified or identifiable natural person; an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person;

A health record can include a range of different records from the multidisciplinary team e.g.

- Care Plans
- Hand written hospital nursing and medical records
- G.P. and other members of the primary health care team records

- Outpatient records and examination/test results/monitoring equipment print outs/ photographs of the patient
- X-rays, pathology other laboratory records
- Digital/electronic records

Patient records include traditional communications with the patient such as letters to and from the patient or their G.P. and other information and communications relating to the patient e.g.

- E-mails
- Video
- Tape recordings of nursing handovers
- Telephone conversations
- Text messages relating to the patient

All of these records describe the care delivered to, and received by the patient and as such can be used as evidence in any investigation into the care of the patient. Should legal proceedings arise as a result of an investigation, all or any of these can also be called as evidence in a Court of Law with the individual healthcare practitioner being required to defend their decision making and interventions in relation to any patient care provided.

Health Records Management

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

The key components of records management are:

- Record creation.
- Record keeping.
- Record maintenance (including tracking of record management).
- Access and disclosure.
- Closure and transfer.
- Appraisal.
- Archiving.

- Disposal and Destruction.

DOCUMENT CONTROL

Equality Impact Assessment Date	Not applicable
Sub-Committee & Approval Date	Joint Information Governance Board 16/11/2018

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
1.0	June 2014	June 2016		
2.0	Dec 2016	Dec 2018		
3.0	Dec 2018	Dec 2021		

Statement of changes made from version

Version	Date	Section & Description
v.3	Oct 2018	• Policy moved to new format.
v.3	Oct 2018	• Scope, statement of intent, legal and regulatory obligations removed
v.3	Oct 2018	• Definitions updated in line with General Data Protection Regulations
v.3	Oct 2018	• Duties updated to reflect changes to job descriptions and duties
v.3	Oct 2018	References to and links to Standard Operating Procedure for restricting records, manging records of transgendered patients and manging records 'S' flagged on PDS.

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Yvonne Salkeld	Joint Head of Information Governance	07/11/2018
Stephanie Preston	Associate Chief Operating Officer	07/11/2018
Pam Travers	Associate Direct of Operations Mental Health Care Group	07/11/2018
Tim Evans	Deputy Director of Operations	07/11/2018