Policy Number:	**STRAT/0001/v5(1)**
Issue/Version No:	**5(1)**

Records Lifecycle Management Strategy

Current status:	**Ratified**

Compliance
All members of Tees, Esk and wear Valleys NHS Foundation Trust staff will adhere to the parameters of Trust policies. The consequences of non-compliance may include disciplinary action and/or legal action.

Document Control

Application	This policy pertains to all areas, departments and services of Tees, Esk and Wear Valleys NHS Foundation Trust.
Associated policy reference and title	Records Lifecycle Management Policy, CLIN/0013/v8
Date of ratification	01 October 2013
Date of review	01 April 2015
Replacing	STRAT/0001/v5
Lead	Louise Eastham, Head of Information Governance and Records Management
Members of working party	Louise Eastham Theresa Parks

This policy document has been agreed and accepted by: (Director)		
Name	Designation	Date
Colin Martin	Director of Finance and Information	

This policy has been approved by subgroup of Executive Management Team or Clinical Governance and Clinical Risk Committee:	
Information Strategy & Governance Group	March 2012

This policy document has been ratified by:	
Trust Board or Trust Board Sub Committee (please specify)	Date of Trust Board or Sub Committee
Executive Management Team	01 October 2013
This policy has gone through an equality analysis (EA)	Date of EA March 2012

Amendments

1 October 2013 – Responsible director changed from Director of Nursing and Governance to Director of Finance and Information

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1. INTRODUCTION

Records Management is defined as the field of management responsible for the systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records. (BSO ISO 15489-1:2001(E))

This strategy relates to all records (clinical and non-clinical operational records) that are held in any format within the Trust and has been developed using guidance from the Records Management: NHS Code of Practice.

This code:

- Sets out the legal obligations for all NHS bodies to keep records that are created, received and maintained as evidence by an organisation or person, in pursuance of their legal obligations or in the transaction of business;

- Explains the actions needed from Chief Executives and other managers to fulfil these obligations;

- Replaces previous guidance taking into account recent developments in records management, the increased use of electronic records and the new areas of legislation that impact on records management systems *i.e.:*

    - The Re-use of Public Sector Information 2005
    - The Freedom of Information Act 2000
    - The Environmental Information Regulations 2004
    - National Care Record Service
    - Personal Demographics Service

• Provides guidelines on good practice;

• Explains the requirements to select records for permanent preservation, lists suggested minimum period for retention for NHS records and;

• Indicates where further information may be found.

2. BACKGROUND

Records management is most effective when it commands commitment from senior managers and is regarded as a professional activity requiring specific expertise. Records are a valuable resource because of the information they contain. That information is only usable if it is correctly recorded in the first place, is regularly updated and is easily accessible when it is needed. An

effective records management service ensures that such information, whatever medium, is properly managed and is available:

- to support patient care and continuity of care;
- to support day to day corporate activities which underpin delivery of care;
- to support sound administrative and managerial decision making as part of the knowledge base for NHS services;
- to meet legal requirements, such as those relating to the storage, handling and disposal of records as well as requests from patients under access to health records legislation;
- to assist clinical and corporate audits;
- to support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the future needs of research, whenever and wherever there is a justified corporate need for information, and whatever media it is required;
- to ensure that the management of such data is appropriate and that any risks to the integrity of the data are minimised.

3. AIMS

The aims of the Trust's records management strategy are to ensure:

- A systematic and planned approach to records management covering records throughout their lifecycle from creation through to disposal;
- Efficiency and best value through improvements in the quality and flow of information and greater co-ordination of records and storage systems;
- Compliance with statutory requirements;
- Awareness of the importance of records management and the need for responsibility and accountability at all levels;
- Appropriate archiving of the Trust's records;
- All aspects of records management are effected and controlled sufficiently well to meet statutory and professional requirements.

4. KEY ISSUES

The records management strategy comprises the following key elements:

4.1. Defining a record

A record is not defined by its physical format or storage medium. The essential characteristic of a record is that it provides evidence of some specific activity. The code of practice defines a record as:

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. (BS 154089.1)

An NHS record is defined as anything which contains information (in any media) which has been created or gathered as result of any aspect of the work of NHS employees – including consultants, agency or casual staff.

The record is the final statement about the transaction or business process which it represents. Once 'declared', it must remain unaltered across time, no matter how many times it is recalled for use. It will contain unique information and/or data and is likely to be the end result of a document and version management process. If the information or data it contains is required for further processing then this should be copied and a new record created.

4.2. Strategic objectives

Accountability - that adequate records are maintained to account fully and transparently for all actions and decisions in particular:

- To protect legal and other rights of staff and patients
- To facilitate audit or examination
- To provide credible and authoritative evidence

The code specifically requires that the records management function be recognised as a corporate responsibility and that managerial focus is placed on records of all types and in all formats, including electronic, throughout their lifecycle.

The organisation, executive team, managers and individual staff are all accountable for the role they play in the records management system.

The integrated records management plan defines responsibilities and objectives to enable the achievement of the tasks required to develop a robust records management system in line with the requirements of Connecting for Health's Information Governance Toolkit (IGT), the NHS Litigation Authority risk management standards and the Care Quality Commission's essential standards of quality and safety.

Quality - that records are complete and accurate, up-to-date and the information they contain is reliable and their authenticity guaranteed. In the records management system the Trust will assure, via the Information Governance and Records Management Group (IG&RMG) that the records management policies and procedures give all staff an 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 against other records and inform them how the information will be used;
- How to identify and correct errors
- The use of information
- How to update information and add information from other sources

The above elements will be looked at in the context of both clinical and corporate records and will include such processes as:

- Corporate record keeping procedures including management of copy documents and records
- Clinical record keeping procedures
- Document control procedures
- Trust wide case note folder standards
- Compliance with Summary Care Record standards
- Freedom of Information Act 2000 procedures
- Implementation of the National Care Record standards
- Data Protection Act 1998 procedures
- Caldicott principles
- Current and future electronic patient information systems

Accessibility and maintenance - that records and the information within them can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the Trust.

Implementing and maintaining an effective records management service depends on knowledge of what records are held, where they are stored, who manages them, in what formats they are made accessible and their relationship to organisational functions.

The records management system will therefore ensure that:

- a full review of the current storage arrangements for records and recommendation is made and a recommendation made as to the future requirements of the Trust together with costings.

- a full audit of all corporate records held is undertaken together with a recommended functional classification scheme for all Trust records. This work will also give direction to the Trust Publication Scheme and is essential in providing a framework for the appraisal and disposal of records and correctly identifying the Trust's vital records.

- the standards required to secure robust systems for the retrieval and movement of records in both an electronic and paper environment is identified and adopted.

- a full risk management profile of all records is undertaken and their status within the Lifecycle is documented and tracked.

- a full review of the business continuity plans attached to records is undertaken and the plans for their preservation is documented in the case of a disaster. This will include Trust wide plans and local recovery plans.

Security - that records will be secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled and audit trails will track all use and changes. Records will be held in a robust format which remains readable for as long as records are required.

Disposition - that there are consistent and documented retention and disposal procedures to include provision for permanent preservation of archival records and that this information is included in a disposition authority.

The records management system will therefore ensure that:

- A full review of all archive records is conducted and where necessary cataloguing and storage issues addressed.

- All records will be considered for their potential disposition at creation. In this way any important information about the record or the classification in which it sits can be identified when the knowledge is current. When a record then comes up for review in thirty years consideration about its value will be understood.

- The disposition process will be built into the electronic records environment so that paper records that undergo disposition and or destruction are matched against their electronic counterparts and the same action undertaken. In this way the Trust will be assured that when the disposition authority indicates that a record has been destroyed there is not an electronic version available.

- All records will undergo a routine appraisal process upon entry to the Archive Libraries and a decision will be made about their ongoing retention or disposal.

- A comprehensive disposition authority will be completed of both electronic and paper records. This will be sourced from the retention and disposal schedules issued within the COP, guidance from professional staff and best practice sources not covered within the COP. The Information governance and Records Management Group will review and recommend the disposition authority to the Information Strategy and Governance Group who will sign off on behalf of the Board.

Training - that all staff are made aware of their record keeping responsibilities through generic and specific training programmes and guidance.

Performance Measurement - that the application of records management procedures are regularly monitored against agreed indicators and action taken to improve standards as necessary. The measures will be agreed by the records management group and reported against at the bi monthly meetings. All exceptions will be followed up and reports made to the records management group.

Partnership Working – that the Trust will develop an inter-agency policy on information sharing between its main partner agencies. This will include aligning, where possible, the retention and disposal schedules that are held in common.

5. CURRENT PLANS

Current work plans to deliver the strategy include:

- Project to standardise the format and content of personnel records including the development of minimum standards for these records;

- Office/desktop domain project is being led by the Information Department with the Director of Nursing & Governance as the sponsor. The project will address the scoping and implementation of electronic document management for all records over the next 24 months and is part of the trust's information strategy. This will ensure the trust keeps records safe, secure and legal according to the latest standards;

- Data quality group – their continued work means improvements are made to ensure information used internally and externally is completed with respect to relevant standards and is accurately reported;

- 'Break the glass' functionality on the electronic patient care record;

- Working closely with clinical teams to support them with space utilisation to enable them to make the most effective use of records secondary storage facilities;

- Implementing the electronic patient record in Yorkshire.

6. REFERENCES

1. Department of Health 2006, Records Management: NHS Code of Practice Part1 and Part 2,(April 2006) London, Department of Health.

2. Department of Health 1999, Caldicott Guardians(HSC1999/012). London, Department of Health.

3. Department of Health 2000, Data Protection Act 1998: Protection and Use of patient Information. London, Department of Health.

4. Department of Health 2003, Confidentiality: NHS Code of Practice. London, Department of Health.

5. British Standards Institute 2001, BS ISO 15489-1, Information and Documentation – Records Management Part 1: General. BSI

6. Information Governance Toolkit for Mental Health Trusts 2012

7. Healthcare Standards Unit

8. NHS Litigation Authority (NHSLA) 2012, Mental Health and Learning Disability Clinical Risk Management Standards, (April 2012) http://www.nhsla.com

7. GLOSSARY OF TERMS

This glossary of terms is set in the context of Mental Health and Learning Disability records.

Active Clinical Records - clinical records which are in use because the patient is currently receiving services.

Appraisal - the process of evaluating business activities (clinical or corporate) to determine which records need to be captured and the length of time that records need to be kept, in order to meet business needs.

Archive Clinical Record - a collection of clinical records relating to a patient that has been preserved. These records will never or are unlikely to be used again. This could be because the patient has died or fully recovered. Such records may be retained long-term for significant medical or historical reasons.

Business Activities - the functions, processes, activities and transactions of an organisation and its employees.

Caldicott Guardian - a senior manager at Board level with the responsibility of safeguarding and governing the use made of confidential patient information within NHS organisations.

Care Co ordination - care co-ordination is the framework via which the statutory agencies deliver care to people with mental health problems and learning disabilities.

Classification - the process of systematically and consistently categorising records to facilitate their capture, retrieval, maintenance and disposal.

Clinical Audit - a process used to validate record keeping practice against current standards and to recommend changes to improve practice.

Clinical Record - a single central record used by the multidisciplinary or interagency team containing all relevant information on the patient. Any professional contributing to the care of the patient inputs information via summary reports into this record.

Clinical Note - a collection of uni-disciplinary contemporaneous working notes detailing the professional's involvement used as an aide memoir.

Confidentiality - personal information given or received in confidence for one purpose may not be used for different purposes or passed to anyone else without the consent of the provider of the information, even after the death of the patient.

Context Information - used to describe the circumstances surrounding a record's creation and use. Such information ensures that a record maintains its reliability and authenticity over time.

Data Protection Act - establishes a set of principles of fair and lawful processing of information; collection and processing of information for specific purposes; obligation to ensure information is accurate, up to date and retained in a form which identifies the subject only for as long as is necessary for the purpose. Ensures that appropriate security measures are in place.

Disposition - a range of processes associated with record appraisal. These include the retention, deletion or destruction of records in or from record keeping systems. They may also include the migration or transmission of records between record keeping systems, to assure accessibility.

Document Image Processing (DIP) – a method whereby documents are scanned and then indexed and stored on optical discs.

Document - refers to anything in which information is stored or from which information may be reproduced.

Electronic Document - information which is created, stored and disseminated electronically.

Health Act Flexibilities - a government initiative intended to give flexibility to local partners. It provides a unique opportunity to foster closer working relationships between the NHS and local government, particularly Social Services. It includes lead commissioning, integrated provision and pooled budgets.

Institute of Health Records Information Management (IHRIM) - providing professional competency training for clinical records staff.

Inactive Clinical Record - clinical record that is not in use because the patient is not currently in receipt of services. The clinical record is retained because the patient is likely to receive services in future.

The NHS Litigation Authority (NHSLA) - provides an extensive risk management programme. The core of their risk management programme is provided by a range of standards and assessments. Most healthcare organisations are regularly assessed against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks.

PARIS - computerised patient information system used by the Trust. Now referred to as the 'Complete Care Record'.

Record - 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. (BS 154089.1)

Retention - the Department of Health has produced guidance on minimum retention periods for clinical records which depends upon their importance and if they are likely to be needed again even after the death of a patient.

Sharing Information - information held in one agency that is shared with partner agencies.

SSID - Social Services Computerised Information management System.

Tracking - s a system whereby there is accurate recording and knowledge of the whereabouts of records so that the information they contain can be located quickly and efficiently. Tracking systems can be manual or electronic.

Unified record - another name for the single clinical record used by all professionals in the interagency or multidisciplinary team providing care to the patient. Where clinical records and uni-professional clinical notes are stored together the collective are still classed as unified records as they are cross referenced to show the full extent of records existing for the patient. PARIS is now the single record used by the Trust with all paper records referred to as subsidiary records.