# RECORDS MANAGEMENT POLICY

## Version 8.0

<table>
<thead>
<tr>
<th>Purpose:</th>
<th>To outline the lifecycle of a record and to provide guidance on retention and disposal of the Trust’s records.</th>
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<tbody>
<tr>
<td>For use by:</td>
<td>All Trust staff.</td>
</tr>
<tr>
<td><strong>This document is compliant with/supports compliance with:</strong></td>
<td>• Department of Health – Records Management: NHS Code of Practice, March 2006</td>
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<tr>
<td></td>
<td>• NHSLA Standard 1.8</td>
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<tr>
<td></td>
<td>• Care Quality Commission Outcome 21</td>
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<td></td>
<td>• Information Governance Toolkit</td>
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<tr>
<td><strong>This document supersedes:</strong></td>
<td>Records Management Policy v7.0</td>
</tr>
<tr>
<td><strong>Approved by:</strong></td>
<td>Information &amp; Records Governance Group</td>
</tr>
<tr>
<td><strong>Approval date:</strong></td>
<td>6 January 2014</td>
</tr>
<tr>
<td><strong>Approval noted by:</strong></td>
<td>Healthcare Governance Committee</td>
</tr>
<tr>
<td><strong>Date noted:</strong></td>
<td>12 March 2014</td>
</tr>
<tr>
<td><strong>Implementation date:</strong></td>
<td>6 January 2014</td>
</tr>
<tr>
<td><strong>Review date</strong></td>
<td>6 January 2017</td>
</tr>
<tr>
<td><strong>In case of queries contact:</strong></td>
<td>Records &amp; Information Governance Manager</td>
</tr>
<tr>
<td><strong>Directorate and Department</strong></td>
<td>Trust Records, Directorate of Business Performance &amp; Technology</td>
</tr>
<tr>
<td><strong>Archive Date ie date document no longer in force</strong></td>
<td>To be inserted by Information Governance Department when this document is superseded. This will be the same date as the implementation date of the new document.</td>
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<td><strong>Date document to be destroyed: ie 10 years after archive date</strong></td>
<td>To be inserted by Information Governance Department when this document is superseded.</td>
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Version and document control:

<table>
<thead>
<tr>
<th>Version number</th>
<th>Date of issue</th>
<th>Change Description*</th>
<th>Author</th>
</tr>
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<tbody>
<tr>
<td>1.6</td>
<td></td>
<td>Addition of Cause of death certificate counterfoils to retention schedule</td>
<td>Trust Records Manager</td>
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<tr>
<td>1.7</td>
<td></td>
<td>ITU scanning addition. Pathology records retention period</td>
<td>Trust Records Manager</td>
</tr>
<tr>
<td>1.9</td>
<td></td>
<td>Addition of updated NHS retention schedule</td>
<td>Trust Records Manager</td>
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<tr>
<td>3.0</td>
<td>Oct 07</td>
<td>Addition of monitoring and dissemination information</td>
<td>Trust Records Manager</td>
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<tr>
<td>4.0</td>
<td>Oct 08</td>
<td>Reformating into Trust standard Cross reference to Medical Records Policy</td>
<td>Trust Records Manager</td>
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<tr>
<td>5.0</td>
<td>March 09</td>
<td>Insertion of new Retention and Disposal Schedule as issued by the Department of Health January 2009</td>
<td>Trust Records Manager</td>
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<td>5.1</td>
<td>Feb 10</td>
<td>3.5 Addition of scanning records into eDITH.</td>
<td>Trust Records Manager</td>
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<tr>
<td>6.0</td>
<td>April 10</td>
<td>Minor amendments</td>
<td>Trust Records Manager</td>
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<tr>
<td>7.0</td>
<td>Jan 12</td>
<td>Replace eDITH with Evolve, replace IG manager with Records &amp; IG Manager, update organisational responsibility.</td>
<td>Records &amp; IG Manager</td>
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<tr>
<td>8.0</td>
<td>Jan 14</td>
<td>Change refs to Information &amp; Records Governance Group Change approval noted to HGC</td>
<td>Records &amp; IG Manager</td>
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</tbody>
</table>

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

Hospital documents may be disclosed as required by the Freedom of Information Act 2000.

Sharing this document with third parties

As part of the hospital’s networking arrangements and sharing best practice, the hospital supports the practice of sharing documents with other organisations. However, where the hospital holds copyright to a document, the document or part thereof so shared must not be used by any third party for its own commercial gain unless this hospital has given its express permission and is entitled to charge a fee.

Release of any strategy, policy, procedure, guideline or other such material must be agreed with the Lead Director or Deputy/Associate Director (for hospital-wide issues) or Directorate/ Departmental Management Team (for Directorate or Departmental specific issues). Any requests to share this document must be directed in the first instance to the Records & Information Governance Manager.

For further advice see the Development and Management of Strategies, Policies, Protocols, Procedures, Guidelines and other Guidance Material Policy.
## CONTENTS

Section 1 - Introduction
1.1 Policy Statement and Rationale 4
1.2 Key Principles 4
1.3 Background Information – if necessary 4
1.4 Definitions 5

Section 2 – Duties and Responsibilities 5
Section 3 – Records Procedures 6
Section 4 – Training and Education 9
Section 5 – Development and Implementation including Dissemination 9
Section 6 – Monitoring Compliance and Effectiveness 9
Section 7 – Control of document including archiving arrangements 9
Section 8 – Supporting Compliance and References 10

Appendix 1 Ipswich Hospital Retention and Disposal Schedule 11
Appendix 2 – Organisational Responsibility for Records Management 11
Appendix 3 – Information Governance Group Terms of Reference 12
SECTION 1 - INTRODUCTION

1.1 Policy Statement and Rationale
The purpose of this policy is to set out the overall aims and objectives of the Ipswich Hospital NHS Trust in the effective management of its records.

Effective records management is one element of information governance. There are records management standards in the Information Governance Toolkit and the achievement of Toolkit standards forms part of the overall Care Quality Commission assessment for the hospital. The adoption of corporate procedures, practices and standards is essential to ensure effective records management is consistently applied throughout the Trust in a systematic and sustainable manner.

Recent legislation, particularly the Freedom of Information Act 2000, has a significant effect on records management in public authorities. The hospital must ensure that records management policies and procedures are fully compliant with the new legislation and with Government policy on the management of information.

In line with The National Archives’ Records Management Standards and Guidance, the policy statement for the Ipswich Hospital NHS Trust is that it is committed to adopting:

A systematic and planned approach to the management of records within the organisation, from the moment the need for a record to be created is identified, through its creation and maintenance to its ultimate disposal ensures that the organisation has ready access to reliable information. An organisation needs to maintain that information in a manner that effectively serves its own business needs, those of Government and of the citizen, and to dispose of the information efficiently when it is no longer required.

1.2 Key Principles
- To support the guidelines contained in the Department of Health Records Management: NHS Code of Practice (March 2006).
- To identify the way in which the management of records in The Ipswich Hospital NHS Trust is currently structured.
- Accountability – to ensure accurate records are maintained for legal, audit or examination purposes.
- To provide documented retention and disposal schedules to include provision for permanent preservation of archival records.

1.3 Background Information
All NHS records are Public Records and must be kept in accordance with the following statutory and NHS guidelines:
- Records Management: NHS Code of Practice March 2006
- Care Quality Commission – outcome 21
- The Freedom of Information Act 2000
- Data Protection Act 1998
1.4 Definitions

- Record – any information held on any format eg paper, CD, microfilm (not restricted to medical records)
- ED – Emergency Dept
- CCU – Critical Care Unit
- FOI – Freedom of Information
- DP – Data Protection
- SAN – Storage Area Network

SECTION 2 – DUTIES AND RESPONSIBILITIES

2.1 The Information & Records Governance Group is responsible for approving the content of this policy and monitoring its compliance and effectiveness.

2.2 The Healthcare Governance Committee is responsible for noting the approval of this policy.

2.3 The Chief Executive and Senior Managers (defined as Band 8 or above) – are personally accountable for records management within the organisation

2.4 The Records & Information Governance Manager is responsible for records management within the hospital and for monitoring compliance and effectiveness of this policy. They are the responsible officer of this policy.

2.5 It is the responsibility of all staff to comply with this policy in carrying out their duties within the hospital and for bringing any areas of non-compliance or queries on its application to the attention of their line manager.
SECTION 3 – RECORDS PROCEDURES

3.1 Related Documents

Please read in conjunction with:
- Health Records Management Policy & Procedures
- Freedom of Information Policy
- Data Protection Policy
- IM&T Security Policy

3.2 Records Management Lifecycle

Records lifecycle in records management refers to the following stages of a records "life span": from its creation to its preservation (in an archive) or disposal.

3.3 Records Creation

The content of a record will primarily be determined by the purpose for which it is being created, for example a personnel file will contain information about an employee relating to things like employment history etc, a patient casenote file will contain information about diagnosis and treatment.

Records of business activity should be complete enough to:

- Facilitate an audit or examination of the business
- Protect the legal and other rights of The Ipswich Hospital NHS Trust, its patients and any other person affected by its actions
- Provide authenticity of the records so that the evidence derived from them is shown to be credible and authoritative.

3.4 Records Storage

3.4.1 On-site

Hard copy Medical Records are stored in the main library and 5 other satellite storage areas within the hospital. Electronic Medical Records stored or generated within Evolve are stored on a SAN. Departmental non-clinical records are stored locally within each section and in on-site storage areas – details of these records and their locations can be found in the following database: g:\spud\information\information governance\records audit.

3.4.2 Off-site

Offsite storage is managed by an external contractor – they offer active storage, semi-active storage and deep storage. Requests for records to be sent offsite must go through the Records & IG Manager or Medical Records Manager.
Records archived with our external contractor should be indexed and referenced to the box and should be sent with a review/destroy date (in line with The Ipswich Hospital NHS Trust retention schedule) clearly identified.

3.5 Media Conversion

The Records & IG Manager will assess the suitability of scanning records series on a departmental basis. A business case and project will be developed as appropriate.

It is hospital policy to scan the following records series and to dispose of the original hard copies:

- Medical Records – from 30th November 2009 all brand new patients to the Trust will have records scanned into Evolve. Scanning of older medical records will take place as the project rolls out.
- ED Record Cards – the project for scanning these records commenced in February 2005 and will be an ongoing process.
- CCU/ITU Charts – all hard copy records (ie those not available on the Innovian system) from January 2004 onwards are scanned and retrieved using Alchemy software. Images are held on CD within the IT department.

Records held on CD are stored in compliance with the IT Security Policy and are password protected. CD’s containing scanned images must be encrypted or password protected prior to transfer. If records are transferred via e-mail this must also encrypted and the Trust approved method is nhs.net to nhs.net.

3.6 Records Retrieval

Requests for the provision of clinical records (eg x-rays, physiotherapy) and non-health records (both routine and urgent) should be directed towards the appropriate managers who are responsible for their storage.

Requests for medical records can be made via the medical.records e-mail address, by accessing the record on Evolve or by contacting the emergency notes team who are available 24 hours a day, 7 days a week.

Transport of medical records to and from the off-site storage facilities will be covered within the contractual arrangements of the hospital and the storage contractor. Records requested will normally be delivered within 24 hours – records required outside of normal working hours must be directed through the Medical Records Emergency Notes teams.

The procedure for the processing and tracking of medical records is detailed in the Health Records Management Policy and Procedures.

3.7 Records Closure

Each department controls the closure of inactive files – only staff whose role includes the management of departmental records have the authority to close records.

Inactive records are archived in local storage areas until the retention period is reached.

In the case of medical records, inactive files may be stored in the off-site facility due to space restrictions.
3.8 Retention and Disposal of Records

The Department of Health Retention and Disposal Schedule 2009 link is attached in Appendix 1. This sets out the minimum retention periods for both Health Records and Non-Health Records.

Documents that have been included on this schedule can be destroyed in accordance with the terms of the schedule without additional authority by staff responsible for departmental records. Further clarification should be obtained from the Records & Information Governance Manager where guidance is needed.

To dispose of paper records the following options must be considered:

- Scanning to electronic media
- Deposit with Public Records Office (National Archives) for permanent preservation
- Destruction – confidential shredding

To dispose of electronic records the following options must be considered:

- Records on Evolve are stored with a retention period allocated to them – they are deleted by the System Manager on approval by the Records & Information Governance Manager after review.

If a record due for destruction is known to be the subject of a request for information under the Freedom of Information Act, destruction should be postponed and a new date for destruction applied to that record. This date will be the date of disclosure plus 6 months to allow time for a complaint to be addressed, in line with the FOI policy.

If a document is found to have been destroyed within the minimum specified retention period, this should be reported to the Records & Information Governance Manager. A register of these documents will be maintained and reported to the Information & Records Governance Group.
SECTION 4 – TRAINING AND EDUCATION

Dissemination of Records Management information with particular regard to retention schedules is carried out via broadcast and mandatory information governance training. The Records Management Policy is published on the Ipswich Hospital NHS Trust intranet.

Medical Records staff have specific training on induction to the department.

SECTION 5 – DEVELOPMENT AND IMPLEMENTATION INCLUDING DISSEMINATION

The Records & Information Governance Manager has developed this policy.

Dissemination of Records Management information with particular regard to retention schedules is carried out via broadcast, Records Management Training and mandatory Information Governance training. The Records Management Policy is published on the Ipswich Hospital NHS Trust intranet.

SECTION 6 – MONITORING COMPLIANCE AND EFFECTIVENESS

The effectiveness of this policy will be measured by carrying out records audits. For medical records these are requested by the Information & Records Governance Group as required. The mandatory information governance training figures are also reviewed at the Information & Records Governance Group meetings.

Monthly statistics of successful records retrieval rates are reported to the Information & Records Governance Group quarterly.

An annual report is published and sent to the Patient Safety and Clinical Effectiveness Group for information purposes.

This policy will be reviewed and ratified every three years by the Information & Records Governance Group. The organisational responsibility for Records Management is shown in Appendix 2.

SECTION 7 – CONTROL OF DOCUMENTS INCLUDING ARCHIVING ARRANGEMENTS

7.1 Once approved the Responsible Officer will forward this guideline to the Information Governance Department for a document index registration number to be assigned and for the guideline to be recorded onto the central hospital master index and central document library of current documentation.

7.2 In order that this guideline adheres to the hospital’s Records Management Policy, the Information Governance Department will:

- Ensure that the most up-to-date version of this guideline is stored on the documentation library
- Archive previous versions of this guideline
- Retain previous versions of this guideline for a period of time in accordance with the NHS Records Retention and Disposal Schedule
SECTION 8 - SUPPORTING COMPLIANCE AND REFERENCES

8.1 This document supports compliance with:

- Its legal obligations as set out in the Public Records Act 1967
- The requirements of Care Quality Commission Outcome 21, NHS Litigation Authority standard 1.8 and Information Governance Toolkit standards.

8.2 References:

- Data Protection Act 1998.
Appendix 1

[Link to: Department of Health Retention and Disposal Schedule 2009]

If the above link doesn’t work please use the following url:


Appendix 2

Organisational responsibility for Records Management
Appendix 3

THE IPSWICH HOSPITAL NHS TRUST

Information & Records Governance Group

TERMS OF REFERENCE

1 Purpose

The Information & Records Governance Group monitors the Information Governance agenda within the Trust and compliance with the Department of Health Records Management Code of Practice.

The group encompasses the following legislation, initiatives or work areas.

- Data Protection Act 1998
- Freedom of Information Act 2000
- Access to Health Records Act 1990
- Computer Misuse Act 1990
- IM&T Security
- Information Governance Toolkit requirements
- Department of Health (DOH) Confidentiality Code of Practice
- DOH Records Management Code of Practice
- Care Quality Commission Outcome 21
- Caldicott Principles

The group has the following aims:

- To support the provision of high quality care by promoting the effective and appropriate use of information.
- To promote and support governance arrangements and provide staff with appropriate tools and training to enable them to work to consistently high standards.
- To develop and monitor policies and procedures that enable all staff to adhere to the principles of information and records governance.
- To oversee the implementation of action plans addressing any failures in records or information governance adherence.
- To provide assurance to the Patient Safety & Clinical Effectiveness Committee on compliance with legislation and national standards.

2 Specific Responsibilities

- To develop and maintain an Information Governance Strategy and policy, Records Management Policy, Data Protection Policy and Freedom of Information Policy.
- To provide high level advice on data protection compliance issues.
- To develop and maintain the Trust's Publication Scheme.
- To respond to new Information Governance related legislation and best practice advice.
• To agree data sharing protocols with external organisations.
• To act as the project board for Information Governance projects.
• To agree and submit the scoring for the Information Governance Toolkit.
• To review complex or contentious issues relating to FOI requests.
• To review arrangements relating to requests for re-use of Trust information under the Re-use of Public Sector Information Regulations 2005.
• To develop and approve policies and practices for the content, format and quality of the patient clinical records.
• To monitor the Trust strategy for the storage of health records.
• To ensure that policy and practice complies with Care Quality Commission Outcome 21 and NHSLA Standards 1.7 and 1.8.
• To respond to legislation and good practice advice and monitor directorate audits of health records to ensure compliance with policy.
• Approval of clinical forms for use/storage within the patient clinical record.
• Facilitating the transition to an Electronic Patient Record and fostering links with other groups working within the Trust
• Risk reporting in relation to information governance and health records

3 Level of Authority

The Group has delegated authority from the Patient Safety & Clinical Effectiveness Committee on Information and Records Governance issues.

4 Membership and Quorum

Membership will consist of:

Trust Caldicott Guardian (Chair)
Head of Programme Delivery
Data & Security Manager
Records & Information Governance Manager
Information Governance Officer
Division 1 – Governance Manager
Division 2 – Governance Manager
Division 3 – Governance Manager/Risk & Governance Training Co-ordinator
Clinical Directorate – Head Matron
Legal Services Manager
Outpatient Service Manager
Head of Information or Information Specialist
Human Resources Manager (representing the FOIA lead)
Head of Coding & Patient Records
Head of Communications
Head of Print Services

This membership is not exhaustive and the Group may co-opt other members as it sees fit, which may include lay representation.

The following members constitute a quorum:
The Chairman has the authority to exercise an Emergency or Urgent Decision where a particular issue requires an urgent response which cannot be deferred to the next meeting. Any such decision must be made having consulted with at least three other members of the Committee. These three members shall consist of an Information Governance rep, HR rep and IM&T rep. The exercise of such a decision shall be reported to the Trust Secretary and to the Information & Records Governance Group at its next meeting for formal ratification’

There will be a minimum of 4 meetings per year.

The administration for the Group will be undertaken by the Information Governance Team.

5 Arrangements for meetings and circulation of minutes

- The Group will meet quarterly for 1 hour.
- Agendas and supporting papers will be sent one week prior to a meeting.
- The Information Governance Team will minute the meetings, distribute them to the Group and upload them to the Intranet. Minutes will also be copied to the Senior Information Risk Owner and Director of Human Resources.

6 Reporting arrangements

- The Group will produce an Annual Report which will be submitted to the Patient Safety & Clinical Effectiveness Group.

7 Communication

- The Group will report to the Patient Safety & Clinical Effectiveness Group annually on its work, specifically commenting on the completeness and integration of information governance in the organisation, the compliance with records management standards and fulfilment of obligations against the Care Quality Commission Outcome 21.
- The Annual Report will be placed on the hospital’s intranet.
- Representatives on the Group will be responsible for communications with their respective nominating bodies.

8 Review arrangements

These terms of reference will be reviewed annually.