Records Management Policy

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Related Policies & Guidelines:

- Information Governance Policy
- Safe Haven Policy

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Amendment History

Version	Status	Date	Reason for Change	Authorised
1.1		December 2014	Review and formatting	Q&SC

1. Purpose

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through to their lifecycle to their eventual disposal.

The Records Management: NHS Code of Practice© has been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

The Central London Healthcare (CLH) records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Central London Healthcare and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways.

The CLH Management Board has adopted this records management policy and is committed to ongoing improvement of its records management functions as it believes that it will gain a number of organisational benefits from so doing. These include:

- better use of physical and server space
- better use of staff time
- improved control of valuable information resources
- compliance with legislation and standards
- reduced costs

The organisation also believes that its internal management processes will be improved by the greater availability of information that will accrue by the recognition of records management as a designated corporate function.

This document sets out a framework within which the staff responsible for managing the CLH's records can develop specific policies and procedures to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

2. Scope and Definitions

2.1 Scope

This policy relates to all clinical and non-clinical operational records held in any format by the Central London Healthcare. These include:

- all administrative records (eg personnel, estates, financial and accounting records, notes associated with complaints); and
- all patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers, etc.)

2.2 Definitions

Records Management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Central London Healthcare and preserving an appropriate historical record. The key components of records management are:

- record creation;
- record keeping;
- record maintenance (including tracking of record movements);
- access and disclosure;
- closure and transfer;
- appraisal;
- archiving; and
- disposal.

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

In this policy, **Records** are defined as 'recorded information, in any form, created or received and maintained by the Central London Healthcare in the transaction of its business or conduct of affairs and kept as evidence of such activity'.

Information is a corporate asset. The Central London Healthcare's records are important sources of administrative, evidential and historical information. They are vital to the Central London Healthcare 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. Aims of our Records Management System

The aims of our Records Management System are to ensure that:

- records are available when needed - from which the Central London Healthcare is able to form a reconstruction of activities or events that have taken place;
- records can be accessed - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;

- records can be interpreted - the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;
- records can be trusted – the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;
- records can be maintained through time – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- records are secure - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- records are retained and disposed of appropriately - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
- staff are trained - so that all staff are made aware of their responsibilities for record-keeping and record management.

4. Roles and Responsibilities

4.1 Managing Director

The Managing Director has overall responsibility for records management within CLH. 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.

CLH has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

4.2 Caldicott Guardian

The Central London Healthcare's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

4.3 Roles and Responsibilities

All CLH 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 within CLH and manage those records in keeping with this policy and with any guidance subsequently produced.

5. Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Central London Healthcare will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958
- The Data Protection Act 1998
- The Freedom of Information Act 2000
- The Common Law Duty of Confidentiality
- The NHS Confidentiality Code of Practice

and any new legislation affecting records management as it arises.

6. Retention and Disposal Schedules

It is a fundamental requirement that all of the Central London Healthcare'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 Central London Healthcare's business functions.

The Central London Healthcare has adopted the retention periods set out in the Records Management: NHS Code of Practice. The retention schedule will be reviewed annually.

7. Records Management Systems Audit

The Central London Healthcare will regularly audit its records management practices for compliance with this framework.

The audit will:

- Identify areas of operation that are covered by the Central London Healthcare'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 these 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.

The results of audits will be reported to the Central London Healthcare Board.

8. Training

All Central London Healthcare staff will be made aware of their responsibilities for record-keeping and record management through generic and specific training programmes and guidance.

9. Review

This policy will be reviewed every year (or sooner if new legislation, codes of practice or national standards are to be introduced).

Appendix 1 - References

The Public Records Act 1958
http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51

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

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

The Common Law Duty of Confidentiality
http://www.dhsspsni.gov.uk/gmgr-annexe-c8

The NHS Confidentiality Code of Practice
https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice