Shropshire Community Health NHS

NHS Trust

Introduction to Records Management

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Contents

The aim of this document is to give a brief overview of Records Management, guidance and best practices that are recommended within Shropshire Community Health NHS Trust (SCHT). It also gives signposting and contact details where to find further information and guidance.

Introduction

Records Management covers all aspects of how we deal with information, both clinical and corporate, on a day to day basis. This document has been produced to give some basic guidance to help individuals in their records management activities and draws on guidance from legislation and national regulatory guidance and standards including the NHS Records Management Code of Practice, Care Quality Commission "Essential standards for safety and quality", The NHS Litigation Authority Risk Management Standards and the Information Governance Toolkit requirements.

Records are legal documents and everyone working for the NHS has a common law duty of confidence to clients, staff and their employer. This duty of confidence continues after the death of a patient and after an employee has left the NHS.

Any NHS record, including health records, created by an individual, up to its disposal, is a public record and subject to information requests under the Freedom of Information and Data Protection Acts. It is imperative therefore, that records are closely monitored and managed throughout their life cycle.

Records Life Cycle

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 confidential disposal or archival preservation. The key components of records management are:

- Record creation
- Record keeping and use
- Record maintenance (including tracking of record movements)
- Access and disclosure
- Appraisal
- Retention and Archiving
- Disposal or archival preservation

It is imperative that records are closely monitored and managed throughout their lifecycle.

Record Lifecycle Management

| Create | Use | *Close Record* | Retention | Appraisal | Disposal |

Be aware   *Monitor*   *Control*
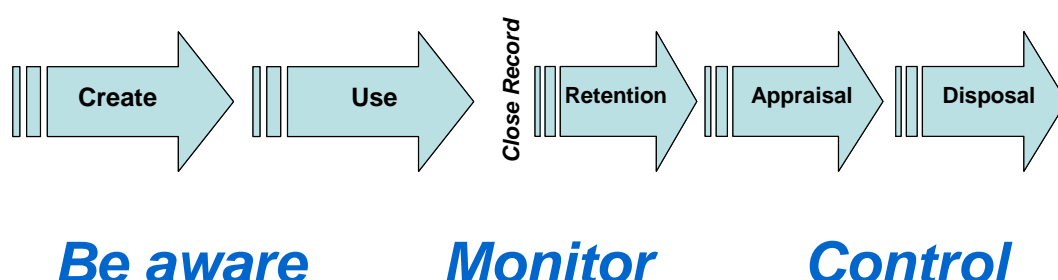
Corporate Records

Corporate records refer to information generated by an organisation other than clinical (or patient) information. The term describes the documents and records generated by an organisation's business activities, and therefore will include documents and records (electronic and paper) from the following (and other) areas of the Trust:

- Trust Board, Committees and Groups
- Personnel / Human Resources / Workforce
- Information Management and Technology (IM&T)
- Financial
- Purchasing / Supplies
- Estates / Engineering

Examples of corporate information:

- Policies and procedures; Strategies and action plans; Minutes and agendas; Reports, e.g. annual, accounting, Board; Financial Standing Orders.

The Trust's procedures, organisational and local, should cover all types of corporate activity where data is collected onto relevant systems. 'Key systems' are defined as key operational systems containing corporate data, e.g. human resources, finance, estates and other organisational management systems.

A document becomes a record when it has been finalised and becomes part of an organisation's corporate information. [1]

Clinical Records

All references to clinical data and information quality refer to patient information for the purposes of assessment. A health record includes any information created by, or on behalf of, a health professional in connection with the care of a patient.

It can therefore cover a wide range of material, and can be held on a variety of media, either paper or electronic. Such as:

- Handwritten medical notes
- Computerised records
- Correspondence between health professionals
- Laboratory reports
- X-ray films and other imaging records
- Photographs, including digital media
- Videos and other recordings
- Audio recordings
- Printouts from monitoring equipment

For more detailed guidance on the use of Clinical Records refer to the Trust's *Clinical Record Keeping Policy*, available on the Trust's website.

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[1] Information Governance Toolkit – Corporate Assurance 601/602

Why do we keep Health Records?

Health records are kept for a number of reasons the key one being to **support patient care and continuity of care**.

Other purposes of keeping health records include:

- Help to address complaints or legal processes, including requests from patients under subject access provisions of the Data Protection Act or other requests under the Freedom of Information Act.

- To support patient choice and control over treatment and services designed around patients

- To support day-to-day business which underpins the delivery of care

- To support evidence-based clinical practice

- To assist clinical and other types of audits

- To support sound administrative and managerial decision-making, as part of the knowledge-base for NHS services

- To support improvements in clinical effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research

Record keeping procedures and processes should cover all types of patient activity where data is collected onto relevant systems and paper held records.

Use of the NHS Number

The NHS Number is the unique identifier the NHS uses to identify and link patient information. Every NHS patient is issued an NHS Number, either at birth (babies in England and Wales) or when they join the NHS by registering with a GP practice. It is a unique 10 digit number.
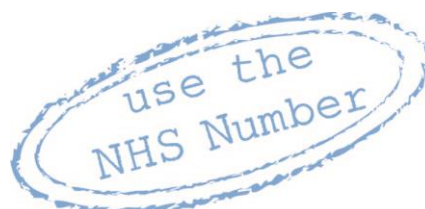
It is the patient's unique NHS Number that will allow NHS staff to quickly and efficiently locate the correct healthcare record on the NHS CRS.

"In terms of clinical governance it is crucial that the NHS Number is included in a patient's record and on all communications regarding their healthcare. Failure to do so could result in the wrong medical history – for example blood group, allergies, medical conditions being associated with the wrong patient, with potentially life threatening consequences" [2].

For more detailed guidance on the use of the NHS Number refer to the Trust's *NHS Number Retrieval Verification and Use Procedure* and the Trust's *NHS Number web page* for further information and best practice guides.

Electronic Staff Records (ESR)

As with the NHS Number for clinical records the ESR number should be used for staff in the appropriate corporate / personnel records.

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[2] http://www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber

Personal Identifiable Data

Personal Identifiable Data (PID – also referred to as Personal Confidential Data - PCD) is data that contains sufficient information to be able to identify the specific person to whom the data belongs (patient or staff) e.g. name, date of birth, address. This information must not be passed to on to other people without the consent of the person concerned except as permitted under the Data Protection Act or under the common law where there is an over-riding public interest. Further information is contained within the Trust's *Data Protection Policy* and *Confidentiality Code of Practice.*

When transferring PID information staff must ensure this is done securely using suitable security encryption e.g. secure e-mail, encrypted laptops and memory sticks a Guidance can be found in the Trust's *Information Security Policy* and other relevant up to date advice that may be published from time to time.

NHS Identity and Trust Branding

When creating leaflets or brochures it is important that NHS Identity and the Trust's branding guidelines are followed. It is good practice to include contact details for the service / department on the last page and a leaflet reference name / version number and date of approval.

The Trust's *Patient and Public Information Policy* and the *NHS Brand Guidelines* give specific advice and guidance on the use of the NHS identity and brand. In order to portray a professional and business like image it is important that these guidelines are followed.   They cover aspects including use and positioning of logos, layout and standard typefaces (fonts) e.g. Arial. See *Appendix 1* for guidance on use of the Trust's logo. The Trust's Communications and Marketing Manager should be contacted for further advice and guidance.

Procedural Documents

The Trust produces a number of procedural documents including Strategies, Policies, Procedures, Protocols and Guidelines which are an essential part in delivering the Trust objectives, and in the maintenance of high standards of care. The content and headings used will be dependant on the type of document being produced. As a minimum the following headings should be used:

- **Introduction:** A brief description of why the document has been developed. *What is it all about?*
- **Purpose:** What the document is intended to achieve. *Why do we need it?*
- **Definitions:** Key aspects that will need further definition than their common meaning.
- **Duties:** Who is to take action and what they must do (same as Responsibilities) *How does it apply to individuals and groups and what are they expected to do?*
- **Body of policy:** (headings will be according to the content of the policy. *What has to be done?*
- **Consultation:** Who has been consulted and how consultation has been carried out.
- **Monitoring compliance:** How implementation and ongoing compliance is to be monitored, including standards and key indicators
- **References:** Further documents that could be referenced, e.g. external guidance. *What evidence was used to create the document?*

- **Associated documents:** e.g. other Trust policies. *What other documents should I be aware off?*

For further guidance refer to the Trust's Policy on the *Management of Procedural Documents (Strategies, Policies, Protocols and Guidelines)* or contact the Trust's Corporate Risk Manager.

General Formatting Best Practice

The use of standard headers (document title and organisation name) and footers (document file name, page numbers and date) in documents is recommended as this helps to ensure all pages of documents are identified as being part of a main document. A border line below headers and above footers helps to separate them from the body of the document.

Making bold and the use of a different font size should be sufficient to make them headings stand out. Underlines should not be used in headings or body text as they could be confused with hyperlinks. The use of all uppercase in headings is also not recommended as some people find this hard to read.

Use of Abbreviations

It is recognised that the use of abbreviations saves time when writing documents but excessive use of abbreviations can make it hard to understand or follow the flow of the content of a document. Best practice is to only use abbreviations where necessary and to include the full term the first time it is used with the abbreviation in brackets e.g. Care Quality Commission (CQC). This is of particular importance in minutes of meetings as these are evidence of topics discussed and decisions made and may be referred to by someone who does not have the knowledge and background of those who attended that meeting. Additionally when using abbreviations in business or organisational documents it is also advisable to include a glossary at the end of the document listing all abbreviations or terms used.

Document / Records Registers

In order to maintain records and to ensure that they remain current and up-to-date, some form of document control system or register should be used within the Services and Departments. It is recommended that this is held electronically. It should record sufficient information to enable a record or document to be identified and traced when required. This is particular important for health records but also for corporate records such as strategies, policies, meeting minutes, contracts and service level agreements. In order to help identify any document that is created it is good practice to include, at minimum, the filename, page number and date in the document's footer.

It is also important that the organisation can easily identify and access records in order to respond to any Freedom of Information request.

Version Control

Version control is the management of multiple revisions to the same document and enables us to identify one version from another and retrace its evolution. Document versions generally run linearly, version 1, version 2 and so on with sub-versions 1.1, 1.2 etc.

When working with a draft include the word 'draft' in the version and filename. Also include "Draft" as a watermark in the document so that it easy to identify that the document has not been approved.

File Naming Conventions

Naming conventions provide a set of rules which assist in allocating a title to a document at the time of creation, and which also provide a framework for a good filing system. They make it easier for people other than the creator to retrieve records.

Naming conventions for document titles should aim to:

- Give a unique title to each document. Naming a document as just *agenda* or *minutes* without a description of the actual group and a meeting date makes it harder to track that particular document

- Give a meaningful title which closely reflects the document contents and express elements of the title in a structured and predictable order with the most specific information at the beginning of the title and the most general at the end e.g. *Records Management – Working Group – Final Report*

- Give a similarly structured and worded title to documents which are linked (for example, an earlier and a later version)

- When saving files for use on the web use dashes or underscores instead of leaving spaces as these spaces will be replaced with characters such as %20 e.g. *Records Management NHS Code of Practice.pdf* is converted to, *Records%20Management%20-%20%20NHS%20Code%20of%20Practice.pdf* so use *Records_Management_NHS_Code-of-Practice.pdf* instead.

- Avoid the unnecessary use of dates (remembering that the operating system will date-stamp the document at time of creation and edit). Where dates are required use the yyyy-mm-dd format so that files will then appear in chronological order when filed electronically e.g. RM Agenda 2013-01-16, RM Agenda 2013-02-18

- Avoid using all uppercase in filenames as this makes it harder to read e.g. *Records Management NHS Code of Practice* is easier to read than *RECORDSMANAGEMENTNHSCODEOFPRACTICE*

Referencing

A referencing system helps to provide a means of identifying and retrieving records. This can be used when creating a register or index of records or in the actual file and folder naming.

Several types of referencing can be used:

1. Alphabetical
2. Numeric
3. Alphanumeric
4. Keyword

The use of a referencing system for electronic files can help to keep information relating to one area/topic grouped together e.g.

1. By preceding all distribution lists in Outlook with DL all

   distribution lists will appear together in the Address Book

2. The use of numbers at the start of a folder/file can help keep then in a specific order

Filing Structure

A filing structure provides a framework for organising records. Within the Trust records should be filed within a functional filing structure determined by and depending on their relevance within the individual directorates / services. This ensures that records can be efficiently filed, retrieved and archived or, eventually, disposed of. Ideally, the electronic filing structure should reflect the way in which paper records are filed to ensure consistency.

The filing structure could follow the actual the Trust functional organisational structure as below:

Organisational Structure
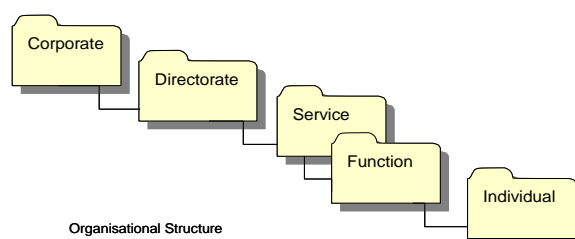
It is recommended that Directorates / Services / Departments / Teams use shared network folders or libraries so that all individuals can access and share relevant information relating to their roles. These network folders should be named from an organisation business perspective and to reflect the role and / or working practices of that area and not a named individual e.g. a folder named Records Manager rather that the Alan F. Access permissions can be set so that only those who need to access these folders can. The IT Service Desk can give further advice and guidance on setting these up.

Backing up Data

It is important that and electronic data is backed up on a regular basis.   In particular staff who use remote computers and / or laptops should ensure the data held on them is backed up to an appropriate location e.g. a network server. For further advice and guidance contact the IT Service Desk.

Tracking of Records

It is important that records are tracked to ensure they can be located quickly and efficiently are not misplaced or lost. One of the main reasons why records get misplaced or lost is because their next destination is not recorded anywhere. It is good practice to e-mail the intended recipient of the record(s) to advise them the record(s) are being sent and for the recipient to confirm receipt. Using e-mails provides an audit trail but also a means of flagging any follow ups required. Tracing / tracking cards should be used to record if a record is taken out of its primary filing location e.g. to be sent to another location for a clinic. This means someone looking for that record is able to trace it as required.

Data Protection Act - Subject Access Request

Patients can ask to access their record by making a subject access request under Data Protection Act (DPA). It is, therefore important, that records can be efficiently retrieved when required and that appropriate tracking processes are in place, particularly for Clinical Records. Staff should also be aware of their local Data Protection Co-ordinator who must record and monitor any Subject Access Requests (SAR). For further information contact the Trust's Data Protection Lead.

Access to Deceased Patients Records

If the request is for a deceased patient this comes under the Access to Health Records Act (1990) which allows access to a deceased patient's records in limited circumstances. It allows access to the health records of deceased individuals for their personal representatives and others having a claim on the deceased's estate. It should be noted that this is subject to certain restrictions e.g. if the patient has left a note to say access should not be given if an application is made after their death. Any requests for access to deceased patient's records would be covered by the same principles as for a Subject Access Request.

For further guidance contact the Trust's Caldicott Guardian, Information Governance / Data Protection Lead or Records Manager

Incident Reporting

In order to ensure appropriate actions are instigated and any lessons learnt are identified it is important that any incidents relating to records are reported to the appropriate line managers and on the Trust's Incident Reporting System (Datix). If in doubt about whether to report an incident, raise it with your line manager and discuss. Please remember that something that may seem minor could be part of a chain of other events that could be potentially more serious. For further guidance contact the Trust's Corporate Risk Manager.

Records Storage, Retention, Archiving and Disposal

The Data Protection Act requires that for legal and practical reasons records must be stored securely and kept for no longer than legally required. The NHS Records Management Code of Practice (Part 2 – Jan 2009) gives guidance on retention schedules for records both Health and Corporate. The Trust's *Records Retention Archiving and Disposal Policy* includes the organisation's recommended Retention Schedules. For further guidance on how long to retain a record please contact the Records Manager.

Local Processes and Local Records Management Leads

It is important that local record keeping processes and procedures are documented to ensure consistent good practice within a service, department or team. They will also assist in any investigation to understand why errors or incidents may have occurred. Individual services, departments or teams should have Local Records Managers or Local Records Administrative Leads who can give advice and guidance on the record keeping practices within their areas.

Training

Records Management is part of Information Governance and is included in the Trust's Mandatory Training; refer to the *Mandatory Training Policy* for further details.

The Records Manager will also deliver Record Keeping briefings and workshops as required, which can be adapted to suit a particular service, department or team's needs.

Related Policies

The following policies can be found on the Trust's web site:

- Records Management Policy
- Records Retention, Archiving and Disposal Policy and Template Code of Practice
- Clinical Record Keeping Policy
- NHS Number Retrieval Verification and Use Procedure
- Clinical Photography Guidelines
- Mandatory Training Policy
- Information Security Policy
- Confidentiality Code of Conduct
- Data Protection Policy
- Freedom of Information Policy
- Information Quality Policy
- Policy on the Management of Procedural Documents
- Incident Reporting Code of Practice

For further advice or guidance please contact:

Alan Ferguson	Records Manager & Quality Facilitator (also Caldicott Support)	01743 277617 or Mbl. 07803 118057
Steve Gregory	Director of Nursing and Operations (also the Trust's Caldicott Guardian)	01743 277588
Gill Richards	Project Manager Information Services (Information Governance and Data Protection Lead)	01743 871998
Sarah Hirst	Project Support for Information Services (Data Protection Co-ordinator)	01743 871968
Andy Rogers	Communications and Marketing Manager	01743 277658
Peter Foord	Corporate Risk Manager	01743 277661
Soma Moulik	Patient Advice and Liaison Service (PALS) and Freedom of Information Manager	0800 0321107
Mark Crisp	Complaints Manager	01743 277616
Deborah Hammond	Organisational Development Manager (Systems Specialist)	01743 276670
IT Service Desk	e-mail: it.servicedesk@shropcom.nhs.uk	0800 181 4050

Useful Links:

Shropshire Community Health NHS Trust Website – Policies	http://www.shropscommunityhealth.nhs.uk/rte.asp?id=10667
The Trust's Records Management web page	http://www.shropscommunityhealth.nhs.uk/recordsmanagement
The Trust's NHS Number web page	http://www.shropscommunityhealth.nhs.uk/NHS-Number/

Useful Links:

Records Management: NHS code of practice Parts 1 and 2 (includes Health Records Retention schedule)	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747
Nursing and Midwifery Council (NMC) The Code	http://www.nmc.org.uk/standards/code/
General Medical Council (GMC) Good Medical Practice: Guidance for doctors,	http://www.gmc-uk.org/guidance/index.asp
Health and Care Professions Council (HCPC) Standards	http://www.hpc-uk.org/publications/standards/
Care Quality Commission – essential standards for quality and safety	http://www.cqc.org.uk/sites/default/files/documents/guidance_about_compliance_summary.pdf
Information Governance Toolkit	https://nww.igt.hscic.gov.uk/Home.aspx?tk=407414259236864&cb=5d7301ac-b97b-48dd-b498-4fc22204932b&lnv=7&clnav=YES
NHS Litigation Authority – Risk Management Standards	http://www.nhsla.com/NR/rdonlyres/6CBDEB8A-9F39-4A44-B04C-2865FD89C683/0/NHSLARiskManagementStandards201213.pdf
NHS Brand Guidelines	http://www.nhsidentity.nhs.uk/about-the-nhs-brand/welcome
Use of the NHS Number	http://systems.hscic.gov.uk/nhsnumber

Appendix 1: Shropshire Community Health NHS Trust Logo Size Guide

On standard formats (A4, A5 etc) the NHS Logo should follow the sizes indicated below.

Shropshire Community Health NHS
NHS Trust
A4 - 8.5mm

Shropshire Community Health NHS
NHS Trust
A5 – 6mm

Shropshire Community Health NHS
NHS Trust
DL – 6mm

Shropshire Community Health NHS
NHS Trust
A6 – 5mm

Shropshire Community Health NHS
NHS Trust
Business Card – 4.25mm

Paper sizes

Shropshire Community Health NHS
NHS Trust

A4 – 210x297mm

Shropshire Community Health NHS
NHS Trust

A5 – 148x210mm

Shropshire Community Health NHS
NHS Trust

A6 – 105x148mm

Shropshire Community Health NHS
NHS Trust
Business Card
54x87mm

Shropshire Community Health NHS
NHS Trust

DL – 99x210m
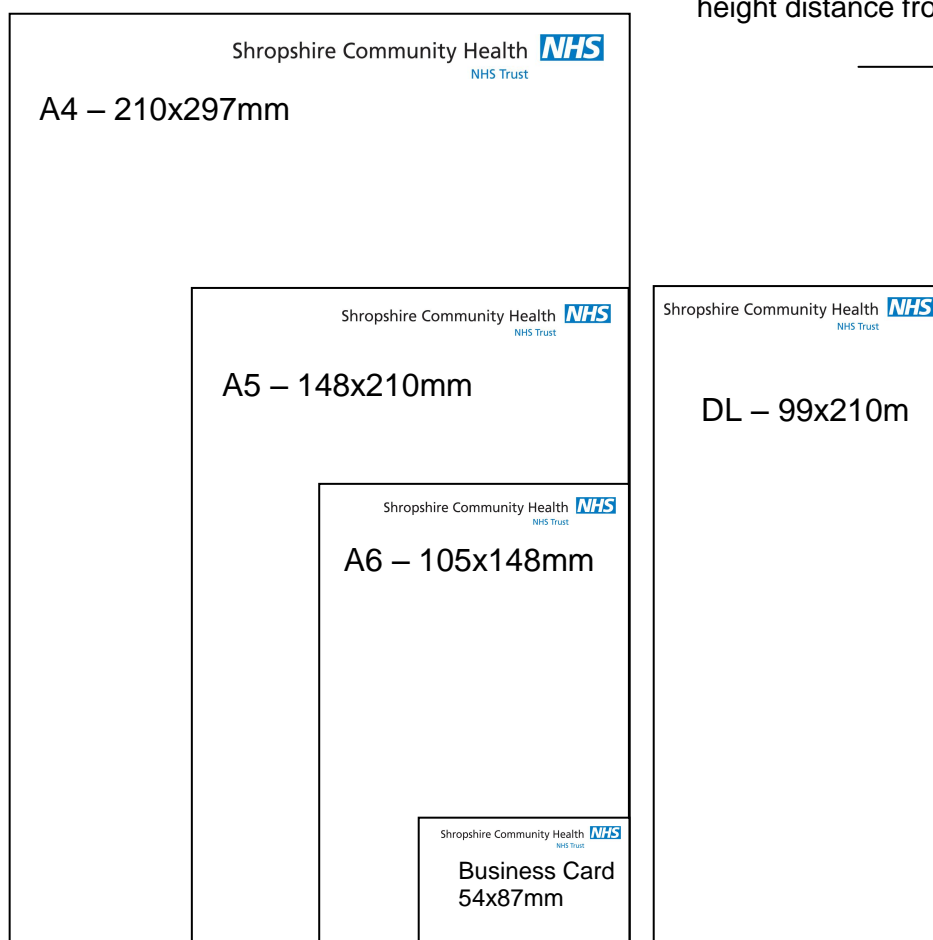
Positioning of logo on the page

As a guide when positioning the logo in the top right-hand corner of the page it should be a logo height distance from the top and side of the paper.

x   x
NHS   x
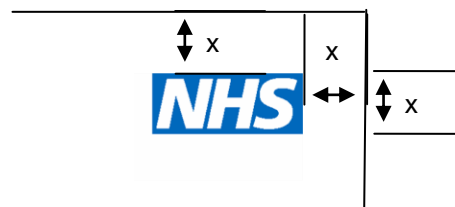
NHS Blue
Pantone ® 300
C 100% M 43% Y 0%
Setting custom colours within MS Office applications -
R 0   G 114   B 198
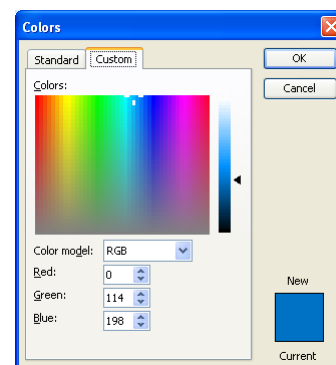
Appendix 2: Key Record Management documents
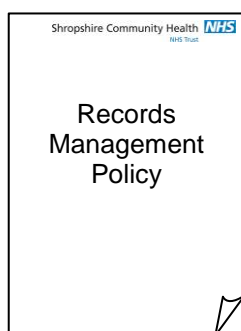
This is the overarching Records Management Policy for the Trust covering all areas of records management and record keeping.
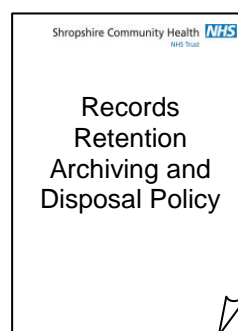
This policy outlines the principles that will be used for the retention, archiving and disposal of records held by the Trust to ensure we only retain records for as long as there is a legal obligation. It contains Retention Schedules covering both Health Records (Appendix 1) and Corporate Records (Appendix 2) and the storage and archiving processes including a checklist to monitor the process.
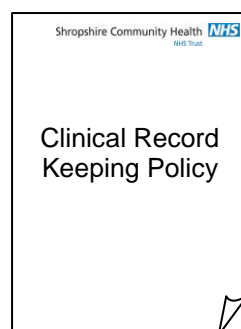
This contains specific guidance on the use of clinical records and has specific requirements relevant to clinical practice. These are based on national legislation, regulations, standards and professional codes of practice.
Key areas covered include: legal obligations; process for creating, tracking, retrieving, retaining and disposing of records; criteria for clinical records audits; frequency of audits; format for audit reports; review of action plans; and monitoring of compliance with all above
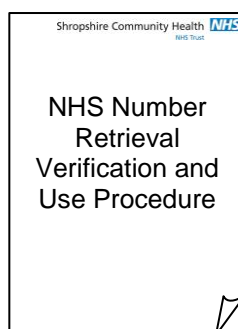
This document gives specific guidance on the use of the NHS Number in line with the national guidance including the NHS Number Programme and the NPSA Safer Practice Notice (NPSA/2009/SPN002). This covers the need to ensure the correct NHS Number is recorded for each active patient and ensure that it is used routinely in clinical communications (Information Governance Toolkit 401).
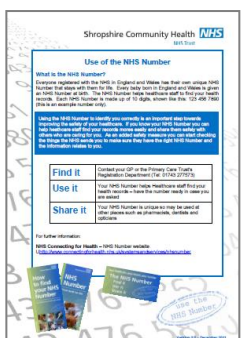
Use of the NHS Number
An introduction to the NHS Number for both the public and staff
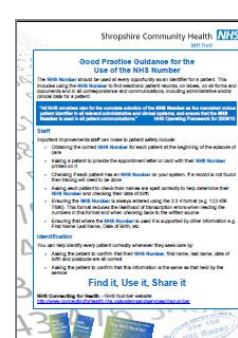
Good Practice Guidance for the Use of the NHS Number
A summary of the key aspects for staff in the best practice use of the NHS Number

Website Links:

Trust policies can be found on the Staff Zone of the Traust Website:
http://www.shropscommunityhealth.nhs.uk/rte.asp?id=10667

- Records Management Policy (ref: 1348/17311):
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10562_1.pdf

- Clinical Record Keeping Policy (ref: 1545/17322):
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10290_1.pdf

- Records Retention, Archiving and Disposal Policy (ref: 1546/17323):
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10563_1.pdf

- NHS Number Retrieval, Verification and Use Procedure (ref: 1547/17324):
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10508_1.pdf

- Use of the NHS Number:
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10646.pdf

- Good Practice Guidance for the Use of the NHS Number:
  http://www.shropscommunityhealth.nhs.uk/content/doclib/10647.pdf

Appendix 3: Record Management Web Pages

Records Management Webpage:
http://www.shropscommunityhealth.nhs.uk/recordsmanagement

NHS Number Webpage: http://www.shropscommunityhealth.nhs.uk/nhs-number

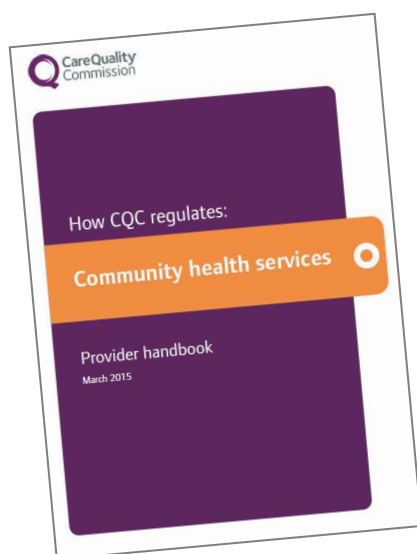# Appendix 4: CQC Keeping Records – Easy Read Version

Regulation 20 - Records
People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.

http://www.cqc.org.uk/sites/default/files/documents/guidance_about_compliance_summary.pdf

http://www.cqc.org.uk/sites/default/files/20150327_community_health_provider_handbook_march_15_update_01.pdf

Outcome 21. Keeping records

People using services should:

- know that their private details will be kept safe

- be happy that private details are used to make sure they get the right care and treatment.

Service providers will make sure this happens by:

- keeping records of care and treatment for all people using their services

- keeping any other records the Care Quality Commission asks them to

- keeping records safe

- making sure that staff can get to the records when they need to

- getting rid of records when they no longer need them.

Appendix 4: Information Governance Toolkit Overview

NHS | **Information Governance Toolkit** | **DH** Department of Health
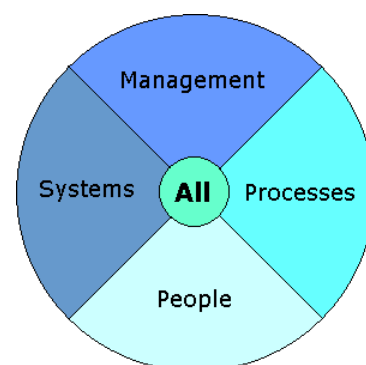
What is Information Governance?

Information Governance is to do with the way organisations 'process' or handle information. It covers **personal information**, i.e. that relating to patients/service users and employees, and **corporate information**, e.g. financial and accounting records.

What is the IG Toolkit?

The Information Governance Toolkit for is a performance tool produced by the Health and Social Care Information Centre (HSCIC) for the Department of Health. It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. Organisations are required to carry out self-assessments of their compliance against the IG requirements.

The Information Governance Toolkit covers these areas as a set of six initiatives or work areas:

1. Information Governance Management
2. Confidentiality and Data Protection Assurance
3. Information Security Assurance
4. Clinical Information Assurance
5. Secondary Uses Assurance
6. Corporate Information Assurance

Records management related requirements:

Req No	Description
Clinical Information Assurance	
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience
401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements
404	A multi-professional audit of clinical records across all specialties has been undertaken
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records
Corporate Information Assurance	
601	Documented and implemented procedures are in place for the effective management of corporate records
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken

For a full list of the requirements:
https://www.igt.hscic.gov.uk/requirementsorganisation.aspx?tk=409357089023473&cb=74a96bd7-5f70-4c48-9aa9-67aeaa12c6e7&lnv=2&clnav=YES