SELDOC Records Management Policy

March 2018

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Applies to	All Staff, Duty Doctors and Pharmacists
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Contents

Introduction and background

Organisations and their staff create, maintain, update, store and retrieve records each and every day. Staff employed by SELDOC has a responsibility to manage these records according to legislative requirements such as the Data Protection Act 1998 (a full list of these legislative requirements can be found at appendix 1).

This policy identifies the systems and processes that SELDOC has introduced to ensure records are managed in an effective and secure way, and these requirements are met. The Policy also identifies what the records management responsibilities are for staff employed by SELDOC, and what processes they should follow to ensure that they meet these responsibilities.

As we have moved into the 21st century, society has seen significant growth in the amount of information sent, transferred and held electronically. In recognition of this, the Department of Health (DH) published ***Records Management: NHS Code of Practice*** in April 2006.

This document replaced all previous NHS guidance, including:

- HSC 1999/053 – For the Record
- HSC 1998/217 – Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients
- HSC 1998/153 – Using Electronic Patient Records in Hospitals: Legal Requirements and Good Practice.

DH also produced a supporting document for NHS organisations, called *Setting and Achieving the NHS Standard for Records Management: A Roadmap*. This document provides practical guidance to the NHS on how to implement the systems and practices identified in the revised Code of Practice.

SELDOC recognises that high quality information underpins the delivery of evidence-based care. Information is most powerful when it is accurate, up to date, meets data quality standards, and is readily accessible and retrievable.

The key legislative requirement in managing records is the Data Protection Act 1998. This Act regulates the processing of personal data, held both manually and electronically; it applies to personal information generally (held both electronically or paper), not just health records, and therefore specifies that the same principles apply to records of employees as well as patients (including their finance, personnel and occupational health records).

Health and Social Care Information Centre (HSCIC)is bringing modern technology into the NHS to improve patient care and services. There are a number of key strands to the Programme, including:

- Care Records Service
- Choose and Book
- Electronic Transmission of Prescriptions
- N3 – the National network
- NHS Mail – the secure, national email service
- Picture Archiving and Communications System
- The Quality Management and Analysis System (QMAS) • GP2GP

The NHS Care Records Service is central to NHS reform, and will transform the way that health and social care information is managed. The service provides an individual electronic NHS Care Record for every patient in England, securely accessible by the patient and those caring for them. It will give authorised professionals access to patient information, and will give patients access to all of their health information. The “Spine” is the name given to this national database. More detailed information about all of the patient’s contacts with the NHS will be held at a local level.

The key information held nationally, together with this local information, will combine to produce the complete patient care record, and includes the following:

- NHS number
- Date of birth
- Name and address
- Allergies
- Adverse drug reactions
- Major treatments

1. Aims and objectives

Organisations are required to have a policy on how records are managed. This statement must be endorsed by the organisation’s Board and communicated to all staff. This policy:

- Sets out SELDOC’s commitment to create, keep and manage records
- Outlines the role of records management within SELDOC, and its relationship with the SELDOC’s overall strategy
- Defines roles and responsibilities, including the responsibility of individuals to document their actions, and to dispose of records appropriately when they are no longer required
- Provides a framework for supporting standards, procedures and guidelines

- Indicates the way in which compliance with the policy and supporting standards, procedures and guidelines are maintained and monitored.

Records management systems and processes allow an organisation to manage its business effectively. This Strategy aims to ensure that the SELDOC complies with the requirements of external bodies such as the Care Quality Commission (CQC) and the Health and Social Care Information Centre (HSCIC)

2. What types of records are there?

The Collins dictionary defines a record as:
"An account in permanent form (especially in writing) preserving knowledge or information about facts and events"

3. Records can be in a number of different formats:

- **Written** – a letter, a paper etc
- **Diagnostic** - X Rays, medical images scans etc
- **Verbal** – a recorded telephone message, a phone call etc
- **Electronic** – an email, a computer database, a CD Rom, call recordings, a text etc

4. Responsibility for records

All NHS records (bar some relating to Sexual health services) are public records under the terms of the Public Records Act 1958. The Secretary of State for Health and all NHS organisations have a duty under this Act to ensure that records and kept safely and correctly disposed of when required.

SELDOC's Board of Directors and Clinical Governance Leads are responsible for ensuring records management systems and processes are in place.

All staff and all clinicians working at working for SELDOC who records, handles, stores, or otherwise comes across patient information has a personal common law duty of confidence to patients and to his or her employer, even after the death of the patient, or after they leave the employ of SELDOC. It is the responsibility of line managers to ensure that their staffs comply with SELDOC's records management policies and procedure.

5. Records Management Systems and Processes

SELDOC is responsible for ensuring that staff are aware of, and use, records management policies and procedures in managing records. All staff should be aware of processes to be used in managing records and are responsible for understanding their role in the following components of the life cycle of a record:

- What they are recording, and how it should be recorded
- Why they are recording it
- How to validate information with patients and carers
- How to identify and correct errors
- What information is used for, and

- How to update information and link it into other data sources.

5.1 Creating a record

Records are created in order to:

- Ensure patients are treated appropriately, according to evidence
- Allow effective controls and management of services
- Facilitate audits and allow analysis of activity
- Meet legal obligations and protect the legal rights of SELDOC, its patients, staff and anybody affected by the SELDOC's actions.

Staff should ensure that they use good practice standards when they name files, to allow for easy identification and retrieval of records.

5.2 Record keeping

SELDOC implements and maintains an effective records management service and all staff have knowledge of what records are, where they are held, who is responsible for them, how to access them, and what organisational function they are for (such as HR, finance etc).

SELDOC Record keeping and filing systems:

- are clearly explained to all staff using them
- include a set of standards or rules for file referencing, titling and indexing
- use simple language in describing records and their contents
- have appropriate access controls in place to update records (senior staff should have more controls over records and record systems than more junior staff).

Following these rules will ensure that SELDOC staff manage records effectively, and know when to ask for guidance. By having these systems in place SELDOC will reduce the likelihood of duplication and also reduce the number of records lost.

Clinical records require a number of controls not usually needed for non-clinical records. SELDOC patient clinical records:

- are recorded as soon as possible after an event to improve accuracy and completeness
- are accurately dated, timed, signed and the carers name printed
- provide evidence of the care planned, the decisions made, the care delivered and the information shared with the patient
- provide evidence of actions agreed with the patient (including consent to treatment and/or consent to share)
- include a number of medical observations such as examinations, tests, diagnoses,
- prognoses and prescriptions
- include disclosures and facts stated by the patient.
- ensure the current record is linked with any previous records that exist for that person, whenever the service is able to reliably identify the person

5.3 Tracking and transferring records

The movement and location of records are controlled to ensure that they can be retrieved easily at any time, and that there is a clear audit trail of ownership. SELDOC has a number of tracking systems in place, all of which should be reviewed to ensure that they include:

- A record number or other identifier
- The person or department where the record is being taken or Sent
- The date when the record has been transferred.

Staff should ensure that any record that is being transported should use a method that ensures confidentiality. Staff should contact their line manager if they are unsure of the appropriate security arrangements required for transporting documents.

It is recognised that some staff will need to take records away from their permanent place of keeping in undertaking their duties. If staff are unaware of the processes they should follow in ensuring records are held appropriately, they should contact their line manager. Staff must never take records home, nor leave them in a vehicle unattended.

Staff should either: hand deliver records, use recorded delivery for transferring records, or ensure that a release form is signed when being given to a Court-accredited official.

5.4 Storing records

Records are stored or archived when they are no longer required for the conduct of current business, and there are different requirements for paper-based and electronic records. SELDOC ensures that any records storage facilities used complies with Health and Safety and Data Protection legislation and requirements.

SELDOC's current method for storage of records is hardcopy storage and SELDOC has an archiving contract in place. The contract will be reviewed during 2018/19 to ensure that they represent value for money, and meet SELDOC's business needs. When considering which archiving type best meets the needs of SELDOC, the totality of costs should be considered, including:

- Pickup and delivery costs
- Box costs
- Retrieval of box costs (depends on speed of need)
- Destruction costs

During 2018/19 all records to be stored and/or archived should be scanned.

The following paragraphs highlight the storage or archiving options that are currently available, and identify SELDOC's preferred option.

5.4.1 Hardcopy storage

This method involves records being stored in boxes at a secure site away from the office. This form of storage is costly, and places a responsibility on staff to identify clearly the

contents of the files being stored, to allow quick retrieval. Storage costs increase over time, unless records outside their retention period are destroyed (for details of the SELDOC's disposal policy, please refer to section 5.5).

5.4.2 Scanning

Electronic scanning of records offers the following benefits:

- Reduced storage requirements (and associated costs)
- Easier and quicker retrieval of records •Improved confidentiality and security.

This system allows for the quickest retrieval of records of the three methods outlined, and allows for the remote, secure accessing of records via the internet. Access to archives can be controlled, ensuring that only appropriate staff access patient and staff records.

5.5 Retention and Disposal Policy

SELDOC is required by law to store records for minimum periods of time, and to have Retention and Disposal Policy. Currently SELDOC retains all records and none are disposed of. SELDOC is at liberty to store records for longer that the DH defines, if it chooses. Staff should refer any queries on document retention to the SELDOC Board for clarification.

This Policy specifies what records can be destroyed, when, and by whom.

Records should be destroyed once they have passed the appropriate retention period. In the same way that relevant information for all documents stored or archived must be maintained by a nominated lead, a list of records that are destroyed must also be kept.

Records not selected for archive and which have reached the end of their administrative life should be destroyed securely, either at the site on which they are stored, or by an approved contractor.

SELDOC is responsible for ensuring that the methods used for destroying records provide adequate safeguards against the accidental loss or disclosure of those records. SELDOC is obliged to receive certificates of destruction from its contractors for all records destroyed, and these should be maintained according to the retention schedule.

If a record due for destruction is known to be subject to a request for information, or potential legal action, destruction should be delayed until disclosure has taken place or, if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted, or the legal process completed.

5.5.1 Disposal of Records

SELDOC will review its core business Retention and Disposal Schedule to determine whether the retention periods are appropriate and continue to meet their business and legal

needs and expectations. These processes will be included in the review of archiving to be undertaken during 2018/19.

5.6 Transferring a record to other organisations

The systems for transferring records from one organisation to another should be tailored to the sensitivity of the material being transferred and the media on which they are held. SELDOC's management can provide advice on the appropriate safeguards to be used. For records being transferred electronically to a GP outside of Lambeth, Lewisham, or Southwark please refer to the Information Sharing Policy and "*Good practice guidelines for General Practice Electronic Patient Records".*

Appendix 1

Legislation covering Records Management

NHS records are public records in the terms of the ***Public Records Act 1958.*** The Chief Executive is thereby personally accountable for records management in SELDOC, and for the safekeeping of its records under the guidance of the Keeper of Public Records. Therefore, all SELDOC records – administrative as well as clinical – need to be created, maintained and disposed of according to the same high standards.

There are a range of legal and professional obligations that limit, prohibit or set conditions in respect of the management, use and disclosure of information and, similarly, a range of statutes that permit or require information to be used or disclosed. Where necessary, the SELDOC should obtain legal advice on the application of these provisions.

The key legal and professional obligations covering personal and other information listed are as follows:

The Abortions Regulations 1991
The Access to Health Records Act 1990
The Access to Medical Reports Act 1988 Administrative Law
The Blood Safety and Quality Regulations 2005
The Census (Confidentiality) Act 1991
The Civil Evidence Act 1995
The Common Law Duty of Confidentiality
The Computer Misuse Act 1990
The Congenital Disabilities (Civil Liability) Act 1976
The Consumer Protection Act (CPA) 1987
The Control of Substances Hazardous to Health regulations 2002
The Copyright, Designs and Patents Act 1990
The Crime and Disorder Act 1998
The Data Protection Act 1998
Directive 2001/83/EC of the European Parliament and of the Council *of 6th November 2001 on the Community code relating to medicinal products for human use*
The Disclosure of Adoption Information (Post-commencement Adoptions) Regulations 2005
The Electronic Communications Act 2000
The Environmental Information Regulations 2004
The Freedom of Information Act 2000

The Gender Recognition Act 2004
The Health and Safety at Work Act 1974
The Health and Social Care Act 2001
The Human Fertilisation and Embryology Act 1990, as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992
The Human Rights Act 1998
The Limitation Act 1980 The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000
The Police and Criminal Evidence (PACE) Act 1984
The Privacy and Electronic Communications (EC Directive) Regs 2003
The Public Interest Disclosure Act 1998
The Public Records Act 1958
The Radioactive Substances Act 1993
The Re-use of Public Sector Information regulations 2005
The Sexual Offences (amendment) Act 1976, subsection 4(1) as Amended by the Criminal Justice Act 1998

Relevant Standards and Guidelines
BSI BIP 0008 BSI PD 5000
BS 4743 BS 5454:2000
BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005
BS 7799-2:2005 ISO 15489
ISO 19005 Information Governance Toolkit

Professional Codes of Conduct
The General Medical Council
The Nursing and Midwifery Council Code of Professional Conduct
The Chartered Society of Physiotherapy
General Social Care Council: Codes of Practice for Social Care Workers and Employers Information on Ethical Practice
Nursing and Midwifery Council Guidance on Record Keeping 01.05 Midwives' Rules and Standards – NMC Standards 05.04

Appendix 2

Data Protection Policy

Introduction

The Data Protection Act 1998 (DPA) requires a clear direction on Policy for security of information within SELDOC. The policy will provide direction on security against unauthorised access, unlawful processing, and loss or destruction of personal information. The following is a Statement of Policy which will apply.

The Policy

- SELDOC is committed to security of patient and staff records.
- SELDOC will display information on their website about data protection.
- SELDOC will take steps to ensure that individual patient information is not deliberately or accidentally released or (by default) made available or accessible to a third party without the patient's consent, unless otherwise legally compliant. This will include training on Confidentiality issues, DPA principles, working security procedures, and the application of Best Practice in the workplace.
- SELDOC will undertake prudence in the use of, and testing of, arrangements for the backup and recovery of data in the event of an adverse event.
- DPA issues will form part of SELDOC's general procedures for the management of Risk.
- Specific instructions will be documented within confidentiality and security instructions and will be promoted to all staff.

Caldicott Guardian
Dr Sarah Donald

Appendix 3

Retention and Disposal Policy

Records should not ordinarily be kept for longer than 30 years. The Public Records Act does, however, provide for records, which are still in current use to be legally retained. Additionally, under separate legislation, records may be required to be retained for longer than 30 years (e.g. Control of Substances Hazardous to Health Regulations).

Organisations should not apply to any records a shorter retention period than the minimum set out in these schedules, but there may be circumstances in which they need to apply a longer retention period. Any decision to extend must ensure that the retention period does not exceed 30 years unless prior approval has been obtained via The National Archives.

Below is SELDOC's retention schedule in the light of its own internal requirements.

- electronic patient records must not be destroyed or deleted for the foreseeable future
- risk assessments; retain the latest risk assessment until a new one replaces it
- purchasing excluding medical devices and medical equipment; 18 months
- general operating policies and procedures; retain the current version and previous version for three years
- any incidents, events or occurrences that require notification to the Care Quality Commission; three years
- use of restraint or the deprivation of liberty; three years
- detention; three years
- maintenance of the premises; three years
- maintenance of equipment; three years
- electrical testing; three years
- fire safety; three years
- water safety; three years
- medical gas safety, storage and transport; three years
- money or valuables deposited for safe keeping; three years
- staff employment; three years following date of last entry

• duty rosters; four years after the year to which they relate • purchasing of medical devices and medical equipment; 11 years
• final annual accounts; 30 years.

The two-part Records management: NHS code of practice is 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. Part 2 only of the code in relation to the retention schedules has been updated in light of guidance and advice given from the NHS and professional best practice