Health and Social Care Records Policy (N-005)

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<u>Policies should be accessed via the Trust intranet to ensure the current version is used</u>

Contents

1. INTRODUCTION

The purpose of this policy is to provide guidance on the procedures and standards required to ensure that records are managed and controlled effectively, commensurate with legal, operational and information needs, and to enable safe and effective patient care.

The Records Management Code of Practice for Health and Social Care 2016, published by the Information Governance Alliance (IGA) 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. The Trust aims to manage all records in accordance with this Code.

This policy relates to all clinical records held in any format by the Trust. Issues specific to the management and use of corporate records can be found in the Records Management and information Lifecycle Policy.

The Trust expects that information contained within health and social care records are correctly recorded, regularly updated, legible, factual and easily accessible.

High quality records support effective clinical judgements, allow easier continuity of care, identify risk and enable early detection of complications, provide documentary evidence of service delivered, promote better communication and sharing of information between members of the multi-professional healthcare team, support patient care and communications and support the delivery of services.

This Policy describes the Trust's approved processes and standards for the creation, use, maintenance, management, storage and destruction of health and social care records.

2. SCOPE

This policy applies to all staff employed by Humber NHS Foundation Trust as well as other health and social care staff such as temporary staff, students, locums and volunteers who document in clinical, and/or non-clinical operational records.

This Policy applies to all health and social care records in either paper or electronic format.

3. 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 Trust 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.
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.
Records	are defined as recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity.
Electronic patient record	Within Humber Teaching NHS Foundation Trust the records held in dedicated electronic health records systems are considered the primary record and all issues reflecting changes in clinical risk should be recorded in the electronic record before the end of a working shift. The electronic patient systems across the Trust are: - Lorenzo, the primary clinical patient record used in the Trust - Systm One, an electronic patient record - PCMis, an electronic patient record used by the Trust's IAPT services - IAPTuS, a national records system for service users of the Trust's IAPT services in community settings - Personal Demographic Service (PDS), also known as the National Spine. A national database containing the latest demographic information for everyone who has received a service from the NHS.
Paper records	are health records not initially recorded on electronic systems and include both handwritten records and paper forms (such as rating scales and observation charts). They may include printouts of information from the electronic record and are in use in areas where no electronic system exists.
Paper light record	will be for the storage of information which cannot be held electronically or for information which needs to be accessed quickly should there be any difficulty with an electronic system. It is important to carefully manage a paper light record system otherwise it will lead to duplication of records and important information being missed.
Contemporaneous records	are made at the same time as the events they record.
Dual record keeping	is where both electronic systems and paper records co-exist for a patient within a service (for example, in the transition period when moving from paper to electronic systems). In

| | these situations the electronic record is considered the primary |

4. DUTIES AND RESPONSIBILITIES

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Department of Health: Records Management NHS Code of Practice. This will couple with:

- The Public Records Act 1958;
- The Data Protection Act 2018;
- The General Data Protection Regulation and Directive (GDPR);
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality;
- The Records Management Code of Practice for Health and Social Care 2016;
- Access to Health Records Act 1990;
- Regulation of Investigatory Powers Act 2000;
- The NHS Confidentiality Code of Practice;
- Guidance from the General Medical Council and the Nursing and Midwifery Council;
- NHS Information Governance: Guidance on Legal and Professional Obligations;
- Code of Practice 'BIP 0008-1:2008: Evidential weight and legal admissibility of information stored electronically;
- Any new legislation affecting records management as it arises from either the Lord Chancellor, the Information Commissioner or a Secretary of State

Chief Executive
Will have ultimate responsibility for this policy, gaining assurance of compliance through the Trust's governance framework, through audit results and monitoring standards specified.

Head of Information Governance, Legal Services and Data Protection Officer
Will have overall operational responsibility for the management of the Medical Records Service and ensure that the policy is implemented Trust-wide. They will also support the Executive Directors in the investigation of reported adverse events related to medical records and breaches in standards specified in this policy and ensure that any lessons learnt are implemented to improve practice and standards.

Directors and Heads of Service
All Directors and Heads of Service are personally accountable for the quality of records management within the Trust, and all line managers must ensure that their staff whether administrative or clinical are adequately trained and apply the appropriate guidelines. Staff must have an up-to-date knowledge of the laws and guidelines concerning confidentiality, data protection and access to health records.

Caldicott Guardian
The Trust's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of personal confidential data. They are responsible for ensuring personal confidential data is shared in an appropriate and secure manner.

Senior Information Risk Owner (SIRO)

The Senior Information Risk Owner (SIRO) has overall ownership of the organisation's information risk and acts as champion for information risk within the Trust. The SIRO is responsible for the on-going development and day-to-day management of the Trust's Risk Management Programme for information privacy and security.

Heads of Divisions/Service/Team/Ward Managers and Matrons
Heads of Care Groups/Service/Team/Ward Managers and Matrons have responsibility for ensuring the quality of clinical records generated by their staff, and monitoring compliance with this policy through the supervision process.

Information Asset Owners (IAO)
Information Asset Owners (IAO) are designated senior managers, are responsible for ensuring that all information assets are managed appropriately.

All Staff
All staff who work for or individuals working on behalf of the Trust are responsible for any records which they create or use in the performance of their duties. Any record that an individual creates is a public record and will be subject to both legal and professional obligations. This responsibility is established and defined by the Public Records Act 1958. Everyone who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to patients and to his or her employer. The duty of confidence continues even after the death of the patient or after an employee or contractor has left the NHS.

Temporary staff such as bank or agency staff, locums, students or volunteers must be advised about the Trust's requirements for record keeping as part of their induction on arrival.

Information Governance Group
The Information Governance Group is responsible for the monitoring of compliance with the clinical records element of this policy, where records are held in paper or electronic form.

Informing Service Users
On first contact service users should be informed by leaflet about the ways the Trust will use and share personal information both internally and with external agencies in accordance with the Care Record Guarantee. The Trust maintains a Fair Processing Notice on the Trust's public website.

5. PROCEDURES

Creation, Structure and Layout of the Integrated Record

5.1. Request for records
When a request for records is received within the Medical Records Department a full manual and electronic search will be carried out. This is to establish if any previous records exist for a patient so that the health care professional who is reviewing them can be sure they are reviewing their whole medical and social care history.

If no previous records can be found all care should be taken to ensure that duplicate records are not made. It is best practice to always search for the patient's records by using the patient's NHS Number. If the patient's NHS Number is not known an 'Advanced Search' should be made on Lorenzo and the search should include the patient's date of birth and gender. If no record can still not be found searches must be made using all

different possible spellings for the surname, for example Philips and Phillips. Search methods must be thorough enough to locate records if an error has been made, for example in the spelling of the name or the date of birth details.

5.2. New referrals

For registrations of new referrals onto electronic record systems, it is the responsibility of the person registering the referral, to ensure that they have as much information to hand. The minimum search criteria would be surname, date of birth and gender. Best practice where available would always be to use the NHS number as the unique identifier.

Once a full search has established that no previous records exist, a new record will be created.

Where the patient record is held electronically, the procedure for registering a patient and creating a new record, will follow the processes described in the relevant procedural documents which are available on the Trust's intranet.

Prior to creating a new record service users should be informed about the ways the Trust will use and share personal information both internally and with external agencies in accordance with the Care Record Guarantee. The Trust maintains a Fair Processing Notice/Privacy Notice on the Trust's public website.

5.3. The NHS Care Record Guarantee

The NHS Care Record Guarantee for England sets out the rules that govern how patient information is used in the NHS and what control the patient can have over this. The NHS Care Record Guarantee can be found at (http://systems.hscic.gov.uk/rasmartcards/documents/crg.pdf).

It covers people's access to their own records; controls on other's access; how access will be monitored and policed; options people have to further limit access; access in an emergency; and what happens when someone cannot make decisions for themselves. Everyone who works for the NHS, or for organisations delivering services under contract to the NHS, has to comply with this guarantee.

5.4. Electronic Records

All new records should be created electronically unless there is a service need for paper records.

When uploading documents the naming of the document should be in line with the naming convention as detailed on the Lorenzo help guide available on the Trust's intranet.

5.5. Integrated records – paper file

The outer cover of the integrated record should be of sufficient strength to ensure protection and expansion of the contents.

The interior of the integrated record should be fitted with a suitable fastening so that new sheets can be added and information is secured within the cover.

The patient should be clearly identified on the front cover (Name, NHS Number, Unit Number) and on each document inside the record.

Every individual sheet and document within the record should be identified with the patient's surname, forename and NHS number. The NHS number should be quoted on all clinical correspondence, both internally and externally.

The inside of the integrated record will be divided into sections. Each section will clearly state the types of documents which are filed within that section.

The filing order within each section of the record should be that sheets and documents are filed in chronological order.

A Chronology of Significant Events sheet will be kept in Section 2 of the integrated record to be used only for recording brief details of all significant events as specified on the documentation, namely:

- Admission and discharges in relation to in-patient services, permanent and respite residential care
- Episodes of violence/self-harm
- Absconsions and returns from/to in-patient units
- Episodes of crisis/relapse
- Mental Health Act assessments and outcome
- Discharges/lapsing/regrading of sections
- Specialist assessments
- Reviews
- Reassessments
- Transfer of care between workers or units

5.6. Defensible documentation for paper and electronic records

Practitioners should follow the recommendations of their professional bodies regarding the use of abbreviations, for example, Nursing & Midwifery Council Guidelines say unnecessary abbreviations should not be used. It should be borne in mind that service users have a legal right to access their health records. Entries should, therefore, always be clear and unambiguous to service users and other professionals involved in their care.

Entries made into the integrated record should be:

- legible
- dated, timed,(time of visit and the duration) and time of entry author's name printed
- designation (band), and signed, for the first entry
- entries made by the same author on the same page, can just be dated, timed and signed in ink that would be readable on any copies (black ink in all cases except for the Pharmacy Service who use coloured ink for certain entries)
- Social Care staff should work to the same standard as Trust staff in regard to the area of recording
- Entries made onto electronic records systems will be via the smart card which will automatically authenticate the identity of the person making the entry.

Practitioners should also adhere to the Essential elements of defensible documentation for paper records and electronic records:

https://intranet.humber.nhs.uk/Downloads/Defensible%20documentation/Essential%20elements%20of%20defensible%20documentation%20-%20paper%20records.pdf

https://intranet.humber.nhs.uk/Downloads/Defensible%20documentation/Essential%20elements%20of%20defensible%20documentation%20-%20electronic%20records.pdf

The record should clearly set out assessment, history, treatment results, care plans, examinations, tests, prescriptions and where there is medical involvement, diagnosis and

prognoses. Any discussions and advice given to the patient must be clearly documented.

The record should identify problems that have arisen and the action taken to rectify them.

The record should provide evidence of the care planned, decisions made (including rationale), the care delivered and information shared.

The record should provide evidence of actions agreed with the patient, including assessment of capacity, consent to treatment and/or consent to disclose information.

The record should include relevant disclosures by the patient pertinent to understanding cause or effecting cure/treatment, facts presented to the patient and correspondence from the patient or other parties.

The record should not include jargon, meaningless phrases, irrelevant speculation, offensive subjective statements or irrelevant personal opinions regarding the patient Every individual sheet and document within the record should be identified with the patient's surname, forename and NHS number. The NHS number should be quoted on all clinical correspondence, both internally and externally.

Entries in the record should be as near as to the same time as the contact with the patient, providing current information on the care and condition of the patient, ensuring contemporaneous records are maintained.

The minimum frequency for entries for inpatients should be at least at the end of every shift and for other contacts, including those by Social Care staff, at least after every session and within 24 hours of the service user being seen.

The entries should be written by the professional seeing the client and not dictated to a secretary or administrator to be typed.

If the practitioner has a problem with writing entries, due for example to some physical impairment (either temporary or long term) this should be discussed with the practitioner's line manager, and advice sought from the Occupational Health Department if appropriate, to establish if there is a suitable alternative solution.

Entries should be chronological and made immediately below the one before, with no spaces between to prevent subsequent insertions being made.

Hull Social Care staff must ensure that each diary entry printed from the Care First electronic record and stored on the integrated file is signed.

Where appropriate, there should be documented evidence within the record that a physical assessment has been carried out in line with the Physical Assessment Policy.

Where tasks are delegated to members of the team who are not registered practitioners the delegating practitioner remains responsible for the overall management of the individual and where the un-registered member of the team records the contact or activity this should be countersigned and the delegating practitioner should ensure that the record is clearly written, accurate and appropriate. Unregistered staff who have been deemed competent to record their own entries and have had this documented in their supervision records do not have to have their entries countersigned.

Local Authority record keeping requirements for unqualified staff should apply to those staff.

All documented entries should be written so as to be compliant with the Race Relations Act and the Disability Discrimination Act.

5.7. Amending records

Any corrections made to errors within the record should be crossed through, signed and dated so that the original entry is still legible. This is required of Health and Social Care Staff.

Corrections or deletion on electronic records systems are done with the strike out, or "marking error" dependent on the system used.

5.8. Documents not to be kept within the Clinical Records – Complaints, Claims and other Records

Documents relating to complaints from a service user or on their behalf should be kept separate from health records. This is subject to the need to record any information which is strictly relevant to their health, in the service user's health record. Anyone who is concerned about where to file information relating to complaints, can send it to the PALS & Complaints Department which will archive the information within the Datix Database. Any duplicate copies will be disposed of confidentially.

Documents relating to legal claims from a service user or on their behalf should be kept separate from health records. This is subject to the need to record any information which is strictly relevant to their health, in the service user's health record. Anyone who is concerned about where to file information relating to a legal claim, should send it to the Legal Services Team which will archive the information within the legal database. Any duplicate copies will be disposed of confidentially.

The following information is also not part of the Health & Social Care Record and should not be uploaded into the patient's clinical records:

- PALS information

- Adverse Incident Forms and supporting documents

- Serious Untoward Incident Reports and supporting documents

- Significant Event Analysis Reports and supporting documents

- Subject Access and Access to Health Records requests

- Freedom of Information Requests made by the patient

- Datix reports

5.9. Sending letters to a patient's GP

When a patient has consented for their information to be shared with their GP, correspondence to the GP shall be both timely (letter to be sent to the GP within 2 working days of assessment) and accurate. With the patient's consent the GP should be provided with the findings of risk assessments following assessment. If historical information is to be shared with the GP it should be clear within the letter that the information is historical.

For guidance on how to print and email letters to a patient's GP please review the guidance note at
https://intranet.humber.nhs.uk/AdminV9/Tracker/ClickTracker.aspx?type=search&id=1285 229|0|-
1|1858896|35963619&indexid=413&terms=printing%20letter&x=/downloads/Systems/Lor enzo/Clinical%2520Notes/Printing%2520and%2520Emailing%2520a%2520letter%2520to

%2520a%2520GP.pdf

5.10. Updating a Deceased Patient's Record

Clinicians are able to add activity/information to a patient record after the patient has been marked as deceased. If the activity/information is added to the records after the patient has passed away (for example where a clinician assesses a patient, but the patient sadly dies before the information about that contact is recorded) it should be clear that the record is being made posthumously. It must be clear on the entry that the records are being updated after the patient has deceased but that the activity occurred prior to the patient's death.

If the national spine gets updated, the patient's details can become locked and the clinician may not able to update the record with the activity details. If there is a problem with updating the record after the national spine has been updated the clinician should contact the Trust's medical record department who would be able to temporarily un-decease the patient's records to allow the entry to be made. Once the entry has been made, the medical records team will mark the patient record as deceased again.

5.11. Prescription Records

Entries relating to prescriptions should adhere to the record keeping standards in the Procedure for Safe and Secure Handling of Medicines.

5.12. Standards for Filing and Managing Volumes

It is the responsibility of all Trust staff with authority to access integrated records or make entries within them, to maintain their quality and ensure documents are filed correctly. The integrated record will generally sit with the practitioner who has the most day-to-day involvement with a particular client namely, the care co-ordinator/inpatient named nurse/primary nurse and it is their specific responsibility for records being kept in good order. If there is a capacity issues with achieving this, this should be fed back to the line manager and an incident/adverse event form completed so as to monitor any issues arising.

All documents must be filed immediately within the integrated record and attached to a clip within the appropriate section with no loose documents of any type. Transparent plastic wallets are not to be used for filing of documents within the integrated record. See Appendix 1 for more information about this.

All machine produced documents such as ECGs or other loose material which cannot be secured on a clip such as psychology tests, psychometric and scoring templates should be placed in a "Secure-Stor" pouch which can be obtained from the Medical Records Department. The pouch should not be used for storing any other types of documents.

A set of records should never be so bulky that it is unmanageable or risks the documents in it being lost or damaged. It should definitely never measure more than 6 cm (2½ inches) wide across the spine. When a set of records becomes full, a new volume should be requested by contacting the Medical Records Department.

When an additional volume of the records has been created it is the responsibility of the person holding the records (the care co-ordinator/ /inpatient named nurse/primary nurse) to ensure the copy and transfer of key items from the previous to the current volume.

These key items are the originals of the following:

- Mental Health Assessment
- Risk assessment

- All other assessments which are pertinent to the current episode of care
- Care Plan
- Most recent CPA review
- Current Risk & Relapse plan
- Notes details of last two contacts/interventions
- ChronologyCore information document

The care co-coordinator/inpatient named nurse/primary nurse should make the final entry in the previous volume at the point a new volume is generated stating which documents have been transferred and into which volume.

All documents should be filed in the integrated record before being returned to the Medical Records Department. If filing turns up after the records have been returned, the records should be requested back from Medical Records to enable the team or unit to complete the filing.

All correspondence should be typed using the corporate style (Ariel 12 font); all pages numbered, include a distribution list where appropriate and double sided to reduce the bulk of the record. Ensure that only one copy is filed within the integrated record.

There should only be one set of integrated records (there may be a number of volumes comprising the set) per patient. Satellite notes are only to be used as a temporary aide memoire as specified within the Protocol for the use of Module/Satellite Notes (See Appendix 3).

5.13. Retrieval, Tracking, Storage and Security of Integrated Records
Staff requiring records should first check on the Trust's patient administration system (PAS) to establish if the patient is known and where the records are located. If the notes are with the Medical Records Department or the patient is not known to the Trust, records will be requested from the Medical Records Department by Lorenzo tracking.

All the required information must be specified on the form to enable the Medical Records Department to process the request as quickly as possible and to reduce the risk of a duplicate record being created.

A record will only be created when there has been a comprehensive search on all relevant PAS and the NHS Spine.

The Patient Document Tracking module is the mandated method of tracing the whereabouts of the integrated records. When leaving the Medical Records Department, records will be traced on the system to a named person within a unit or team. That person will then be accountable for the whereabouts of the record. It will be their responsibility to update the patient document tracking module for any subsequent transfer of the records.

Records should be returned to the Medical Records Department as soon as possible after discharge from the service.

The Trust contracts with a document management company for off-site storage of its health records. The contract includes storage, retrieval, data capture of new records and a weekday daily delivery service to and from the Medical Records Department.

Staff will maintain the security of records and the information held within them in line with the Trust's Safe Haven Policy for the Security of Manual Records and the Caldicott and Data Protection Policy. All records should be returned to a locked filing cabinet within a

locked room at the end of every shift. There should be no records and/or patient identifiable information left within offices that are not securely stored.

5.14. Retention Disposal and Destruction of Records

Clinical records in use in the Trust will be retained for at least the minimum period specified in the Records Management: NHS Code of Practice. This is 20 years after the last date of contact plus a further 10 years following a review of the record.

The Information Governance Committee will identify and recommend the destruction or transfer to other media of any health records. This will be in consultation with health professionals, the Information Governance and Legal Services Manager, the Senior Information Risk Owner and the Caldicott Guardian.

The document management contractor who currently holds the records will ensure that records are destroyed in a confidential manner, accordance with British Security Industry Association (BSIA) & National Association for Information Destruction (NAID) standards. A certificate of destruction will be issued. Any records identified and subsequently destroyed or disposed of (for example transferred to other media) will be marked as such on the patient administration system. The process will be overseen by the Head of Information Governance.

The archiving of electronic records is done via an end of registration facility when the patient is no longer active to a particular service.

Agreement will be reached locally as to which records are to be preserved indefinitely for the purposes of research or for historical purposes.

Records relating to patients suffering from Huntington's Disease can never be destroyed.

If a patient's integrated records are to be kept in their paper-based format (for complaints or litigation purposes) this fact should be clearly marked on the front cover of each volume of the record. Depending on the circumstance, either the PALS and Complaints Manager or the Head of Information Governance and Legal Services should place on the front cover of the record a pre-printed label with the words "This record should not be destroyed or transferred to other media without first seeking the advice of [either] the Trust's [PALS and Complaints Manager] [Head of Information Governance and Legal Services]. Date…………………….."

5.15. Access, Availability and Transfer of Integrated Records

Applications for subject access to integrated records will be through the Medical Records Administration Manager under the terms of the Data Protection Act 2018 and the General Data Protection Regulation as laid out in the Trust's Caldicott and Data Protection Policy, Access to Health Records Policy and Procedure to Access Health Records. Subject access should be further facilitated by the sharing of Care Plans and the Department of Health's Copying letters to Patients initiative.

Requests for transfer of integrated records for a client who has moved to another Trust will be through the Medical Records Department. A photocopy of the record will be sent under recorded delivery to a named person within the requesting Trust. Originals of records must never be sent outside the Humber Teaching NHS Foundation Trust area.

The Medical Records Department will make every effort to ensure that records are available on or before the first contact with the clients, and for unplanned in-patient admissions that the records are available within three working days of the admission. In urgent cases a special delivery can be requested via the Medical Records Department.

After discharge or transfer to another team, or prior to an appointment, records should never be kept for longer than necessary, for example, for the purpose of dictating and typing correspondence. The standard should be no longer than three working days prior to a clinic and two working days after the clinic or discharge.

The scanning facility on the electronic systems will be used for the storage of approved documentation to enable access at all times.

For requests of medical records by the police or Coroners' Office please refer to Disclosing Information to the Police – Operational Procedure found on the intranet.

6. TRAINING

All staff will receive training as part of the Trust's induction programme in maintaining standards in record keeping, the importance of tracking integrated medical records and data protection standards as stipulated in this document. For further training please see the Trust's Training Needs Analysis.

7. EQUALITY & DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

8. BRIBERY ACT

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to 10 years.

The Bribery Act applies to this policy.

9. IMPLEMENTATION

Full implementation has taken place following the development of previous versions. Some additions have been made to the accompanying guidance and these will be communicated to staff by members of the Information Governance Group.

The implementation of this policy requires no additional financial resource.

10. MONITORING & AUDIT

The policy has been produced to ensure the Trust maintains effective records management systems. Managers in all areas where care records are created and

maintained must ensure that staff are adequately trained, aware of, and work within the Trust's policy requirements.

The process for monitoring and evaluating the effectiveness of this policy, including obtaining evidence of compliance will be part of the Information Governance annual audit process through completion of the NHS Connecting for Health Information Governance Toolkit annual assessment.

Local and trust-wide audits will be discussed in the Information Governance Groups.

The Medical Records Department will run a bi-monthly report showing potential duplicate records. The administration lead for Medical Records will check the list against the Trust PAS and any paper records. The records will be merged if it is shown to be a genuine duplicate.

All missing records are reported as an adverse incident via datix. A summary of incidents is reported quarterly to the Information Governance Group.

The quarterly report presented to the Information Governance Group will also show number of records currently in storage, details of any records destroyed or transferred to other media, the number of requests for records which have been received by the Medical Records Department, and the number (if any) of requests outstanding and not yet dealt with.

11. REFERENCES AND SUPPORTING DOCUMENTS

Public Records Act (1958) Sections 3 (1)-(2)
Healthcare Records Policy Version 5
Date of Ratification: 24 March 2017 Page 34 of 43
Data Protection Act (2018)
Access to Health Records Act (1990)
Access to Medical Reports Act (1988)
Freedom of Information Act (2000)
Health and Social Care (Safety and Quality) Act (2015)
Records Management Code of Practice for Health and Social Care (2016)
NHS Information Governance: Guidance on Legal and Professional Obligations (2007)
Information Security Management: NHS Code of Practice (2007)
Department of Health: Guidance for Access to Health Records Requests
Department of Health: Confidentiality: NHS Code of Practice
Supplementary Guidance: Public Interest Disclosures
World Health Organisation International Classification of Disease Code Book Version 10 [ICD/10] available at: www.who.int/entity/classifications
Royal College of Physicians: Generic medical record keeping standards
https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards
Royal College of Physicians: Standards for the clinical structure and content of patient records
https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records
The General Data Protection Regulation and Directive (GDPR): https://ico.org.uk/for-organisations/data-protection-reform

Appendix 1: Document Control Sheet:

Document Type	Policy – Health and Social Care Records Policy		
Document Purpose	This policy sets the minimum standards for clinical record keeping		
Consultation/ Peer Review:	Date:	Group/Individual	
list in right hand columns consultation groups and dates ->	February 18	Information Governance Group	
	March 21	Information Governance Group	
Approving Committee:	Audit Committee	Date of Approval:	
Ratified at:	Trust Board	Date of Ratification:	
Training Needs Analysis:

(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered) | No further training required as a result of policy – training is offered as part of current programme | Financial Resource Impact | None |
Equality Impact Assessment undertaken?	Yes	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	Describe implementation plans below		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:	Adherence of the policy with be monitored by supervision. Audit of supervision will be undertaken across the whole of the organisation on a monthly basis using the audit tool within Survey Monkey https://www.surveymonkey.co.uk/r/YG8QWQD

Training compliance reports are also monitored via Care Groups. | | |

Document Change History:			
Version Number/Name of procedural document this supersedes	Type of Change i.e. Review/Legislation	Date	Details of Change and approving group or Executive Lead (if done outside of the formal revision process)
14.00	Review	14.01.11	Major review updated and ratified
14.01	Review	03.12.12	Reviewed minor changes following NHSLA assessors visit to Section 5.1.3 and Section 10 Monitoring
15.00	Review	01.02.18	Major review updated to provide for legislative changes for GDPR and also to provide for electronic records and references to defensible documentation.
15.01	Amendment	18.09.18	Update references to Data Protection Act 2018.
15.02	Amendment	10.03.21	Update new Trust name. Minor changes to include other records not to be stored with the patient's clinical records. Addition of the need to notify patient of the Trust's privacy statement.
15.03	Review – Minor Amends	30.08.2022	Minor changes to include the NHS Care Record Guarantee, sending letters to a patient's GP and updating a deceased patient's record.

Appendix 2: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services
1. Document or Process or Service Name: **Health and Social Care Records Policy**
2. EIA Reviewer (name, job title, base and contact details) **Lisa Davies, Head of Information Governance and Legal Services, Mary Seacole Building, 01482 477840**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service
The aim of this policy is to ensure that the management of Health and Social Care Records complies with all legal obligations and NHS circulars and guidance such as the Department of Health Records Management Code of Practice for Health and Social Care 2016.
It includes guidance on the use of paper and electronic clinical records. This reflects the Trust's current migration from paper records to an electronic patient record.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This policy aims to ensure that the management of Health and Social Care Records complies with all legal obligations and NHS circulars and guidance such as the Department of Health Records Management Code of Practice for Health and Social Care 2016. Accordingly it aims to have a positive impact on everyone who comes into contact with our services, as we recognise that the accurate recording of confidential information is paramount to the treatment and care we offer our patients.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (and including cancer, HIV, multiple sclerosis)	Low	As above

Sex	Men/Male Women/Female	Low	As above
Marriage/Civil Partnership		Low	As above
Pregnancy/ Maternity		Low	As above
Race	Colour Nationality Ethnic/national origins	Low	As above
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	As above
Sexual Orientation	Lesbian Gay Men Bisexual	**Low**	As above
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	As above

Summary

Please describe the main points/actions arising from your assessment that supports your decision above This policy has been assessed using the Equality Impact Assessment (EIA) Screening Tool, which concluded that it would not result in any adverse impact towards or the positive discrimination of individuals or groups based on any of the protected characteristics; in addition to social inclusion, community cohesion and human rights. No issues have been identified from patient focus groups, PALS & Complaints, CQC inspections, staff surveys. This policy aims to ensure that the management of Health and Social Care Records complies with all legal obligations and NHS circulars and guidance such as the Department of Health Records Management Code of Practice for Health and Social Care 2016. Accordingly it aims to have a positive impact on everyone who comes into contact with our services.

EIA Reviewer: Lisa Davies	
Date completed: 10 March 2021	Signature: Lisa Davies