NHS Darlington Clinical Commissioning Group

Policy Type		Policy Name
Information Governance		**CCG IG06 Record Management Policy.**
Corporate	X	
Standing Operating Procedure		
Human Resources		

Status	Final / Approved
Committee approved by	Governing Body Executive Committee
Date Approved	25 September 2018 14 August 2018
Equality Impact Assessment undertaken	Completed
Distribution	All CCG staff
Planned Review Date	July 2020
Version	4

Prepared By:	Senior Governance Manager, North of England Commissioning Support Unit (NECS)
Consultation Process:	CCG Corporate Governance & Risk Manager

Policy Adopted From:	IG06: Records Management Policy (3.1)

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
V1	28/02/2013	Policy & Corporate Governance Lead, NHS County Darlington & Darlington	First issue
V2	January 2015	Senior Governance Manager, NECS	Reviewed and Updated.
V3	March 2016	Senior Governance Manager NECS	- Reformatted numbering and style of policy. - Section 1.3: Insertion of reference to the Health and Social Care Information Centre. - Section 5.2.6: Removal of reference to 'records management procedure' and insertion of 'consult the information governance service'. - Section 5.7.1: Removal of reference 'Staff without computer network access should contact their line managers for information on how to access policies' and insertion of 'Master copies are held by the governance service' - Section 9.1: Insertion of reference to 'Cabinet Office (2015) Health and Social Care (Safety and Quality) Act 2015. London. HMSO'.
V3.1	October 2017	Senior Governance Manager NECS	Review and update to include GDPR
V4	May 2018	Alan Clement	Updated in line with publication of Data Protection Act 2018.

Approval

Role	Name	Date
Approval (1)	Governing Body	March 2013
Approval (2)	Governance, Risk and Audit Committee	January 2015
Approval (3)	Governance, Risk and Audit Committee	March 2016
Approval (3.1)	Formal Joint Executive Committee	November 2017
Approval (4)	Governing Body Executive Committee	25 September 2018 14 August 2018

Review

This document will be reviewed twelve months from its issue date and no longer than 3 years after its first review.

Contents

1. Introduction

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

This policy sets out the principles of records management for the CCG. It provides a framework for the consistent and effective management of records that is standards based and fully integrated with other information governance initiatives within the CCG. Records management is necessary to support the business of the CCG and to meet its obligations in terms of legislation and national guidelines.

The policy is based on guidance from the Department of Health Records management code of practice for health and social care 2016 and the Records Management Roadmap issued by NHS Connecting for Health (now NHS Digital). Both documents provide guidelines for good practice in managing all types of NHS records and highlight the responsibilities of all staff for the records they create or use.

The CCG has a statutory obligation to maintain accurate records of their activities and to make arrangements for their safe keeping and secure disposal. All records created in the course of the business of the CCGs are public records under the terms of the Public Records Act 1958.

Effective records management is an essential requirement of the commissioning obligations of the CCG. It also recognises the importance of good records management practices to ensure:

- The right information is available at the right time.
- Authentic and reliable evidence of business transactions.
- Support for decision making and planning processes.
- Better use of physical and server space.
- Better use of staff time.
- Compliance with legislation and standards.
- Reduced costs.

This policy should be read in conjunction with the CCG Records Management Strategy (Appendix A) which sets out how the policy requirements will be delivered.

1.1 Status

This policy is a corporate policy.

1.2. Purpose and scope

This policy applies to employees, agents and contractors working for, or supplying services to the CCG. However, it is recognised that primary care practitioners are also part of the organisations and as such this policy is offered for use by them to adapt to their own practices and organisations as appropriate. The contact for the policy is available to offer help and support to primary care practitioners who wish to use and implement this policy.

The CCG records are part of the organisation's corporate memory, providing the evidence of actions and decisions and representing a vital asset to support daily functions and operations.

To provide guidance to staff to carry out their corporate and personal record management responsibilities to support high quality patient care.

To support the organisation and staff in meeting their obligations in terms of legislation and national good practice guidance.

To provide effective governance arrangements for record management, also known as 'information lifecycle management'.

2. Definitions

2.1 **Records:** Recorded information in any form or medium, created or received and maintained by an organisation or person in the transaction of business or the conduct of affairs. Also considered as 'Information Assets'.

2.2 **Health Records:** any record which consists of information relating to the physical or mental health of an individual and has been made by or on behalf of a health professional in connection with that care.

Note: the draft UK Data Protection Legislation defines a health record as, "a record which consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates."

2.3 **Corporate Records:** those records which relate to the corporate business of the CCG such as accounts, minutes and meeting papers and legal and other administrative documents. They may contain personal identifiable information, for example personnel files and should be treated with the same degree of care and security as patient/service user records. Also considered as 'Information Assets'.

2.4 **Records Management:** is a discipline which utilises administrative systems 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.

2.5 **Record Series:** a set of records relating to each other used within a service/department/ward e.g. health visitor or podiatry records.

2.6 **Records Lifecycle:** a period of time a record exists from its creation/receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as semi-active or closed records which may be referred to occasionally) and finally either confidential destruction or archival preservation.

2.7 **Information Asset Owners (IAOs):** are senior individuals who have been designated the responsibility ('ownership') of a record series / information asset. For further detail of the role, please see section 10.

2.8 **Information Asset Administrators (IAAs):** support the IAOs to ensure that policies, procedures and processes are followed in relation to a record series / information asset.

2.9 **Personal Information:** is factual information or expressions of opinion which relate to an individual who can be identified from that information or in conjunction with any other information coming into possession of the data holder. This also includes information gleaned from a professional opinion, which may rely on other information obtained. Personal information includes name, address, date of birth or any other unique identifiers such as NHS Number, Hospital Number, National Insurance Number, etc. It also includes information which, when presented in combination, may identify an individual e.g. postcode, date of birth etc.

Note: the UK Data Protection Bill defines personal data as, "any information relating to an identified or identifiable individual". Identifiable living individual is defined as, "a living individual who can be identified, directly or indirectly, in particular by reference to:

    a)   an identifier such as a name, an identification number, location data or an online identifier, or

    b)   one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of the individual"

3. Records Management

3.1 Records Creation

3.1.1 All records created in the CCG must be created in a manner that ensures that they are clearly identifiable, accessible, and can be retrieved when required.

3.1.2 All records created in the CCG must be; authentic, credible, authoritative and adequate for the purposes for which they are kept. They must correctly reflect what was communicated, decided or undertaken.

3.1.3 Adequate records must be created where there is a need to be accountable for decisions, actions, outcomes or processes. For example, the minutes of a Governing Body meeting, a clinician's examination of a patient, the payment of an account or the appraisal of a member of staff.

3.1.4 For further guidance in the processes and procedures for achieving good practice in records creation, please see the supporting records management procedures.

3.2 Records Use and Maintenance

3.2.1 All staff have a duty for the maintenance and protection of records they use. Only authorised staff should have access to records.

3.2.2 The identification and safeguarding of vital records necessary for business continuity should be included in all business continuity /disaster recovery plans.

3.2.3 Any incidents relating to records, including the unavailability and loss, must be reported as per procedure.

3.2.4 The completion and upkeep of records should comply with the guidance in the data quality procedures. Accuracy of statements i.e. record keeping standards, should pay particular to stating facts not opinions.

3.2.5 Scanning records must be done in accordance with a written service procedure. In addition, if scanning is undertaken in-house, the scanning equipment must be of a quality to meet the British Standards and in particular the 'Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically' (BIP 0008).

3.2.6 For further guidance in the processes and procedures for achieving good practice in records creation, please see the supporting records management procedures.

3.3 Records Tracking

3.3.1 Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently. One of the main reasons records are misplaced or lost is that the next destination is not formally recorded.

3.3.2 All services/departments should ensure they have appropriate tracking systems and audit trails in place to monitor the use and movement of records.

3.3.3 The CCG should ensure an accurate and up to date Information Asset Register is maintained which identifies all information assets held or processed within the CCG in accordance with the General Data Protection Regulations.

3.4 Records Transportation

3.4.1 When records are being transported, whether they are electronic or paper, care should be taken to ensure the safe transition to the new location, whether this be temporary or permanent.

3.4.2 Examples of safe transport includes: electronic – encrypted email (e.g. NHS Mail to NHS Mail), paper – 'track & trace' mail provider option.

3.5 Records Storage

3.5.1 Records storage areas must provide storage which is safe from unauthorised access but which allows maximum accessibility to the records commensurate to its frequency of use. The following factors must be taken into account:

- Compliance with Health and Safety and fire prevention regulations.
- Degree of security required.
- Users' needs.
- Type of records stored.
- Size & quantity of records.
- Usage and frequency of retrievals.
- Ergonomics, space, efficiency and price.

3.5.2   Inactive records stored off-site (secondary storage) must be stored by retention date with the IAO is responsible for keeping an accurate and up-to-date record via the Information Asset Register.

3.5.3   When using an external company to store, retrieve, or destroy information assets a suitable data sharing agreement or data processing agreement should be agreed to ensure the nature of the data processing is clear (see 3.6.3).

3.6   Records Retention and Disposal

3.6.1   Inactive records are retained in line with the Department of Health's Records Management Code of Practice for Health and Social Care 2016. This document only contains records series that have a national minimum retention period; where other records are kept; services/departments must maintain a log of the agreed retention period.

3.6.2   Records due for disposal should be assessed for their research or archival value prior to arrangements being made for their secure and confidential destruction.

3.6.3   There should be appropriate documentation of records containing personal information to be destroyed and where necessary an approved contractor should be used who can provide written record e.g. certificate as evidence of destruction. All record destruction records must be approved by information asset owner responsible for the record series (see 3.5.3).

3.7   Distribution

3.7.1   This policy is available for all staff to access on the CCG website. Staff without computer network access should contact their line managers for information on how to access policies.

3.7.2   All staff will be notified of a new or revised document via the authorised communications media.

3.7.3   This document will be included in the CCG Publication scheme in compliance with the Freedom of Information Act 2000.

3.8   Implementation

3.8.1   All departments in the CCG are expected to use this policy and its related procedures to develop and implement their own records management operational procedures..

4.   Duties and Responsibilities

Council of Members	The Council of Members has delegated responsibility to the Governing Body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Officer	The Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
Information Asset Owners	Information Asset Owners (IAOs) are responsible for: • Liaising with records management/IG leads to ensure that records management practices are in line with the guidance and protocols on confidentiality. • Ensuring appropriate record audits are undertaken. • Ensuring appropriate information governance /confidentiality clauses are in third party contracts relating to records management such as secondary storage, scanning companies before using the company. • Ensuring appropriate consideration is given to records management within business continuity plans. • Ensuring they obtain appropriate certifications of destruction. • Investigate and take relevant action on any potential breaches of this policy supported by other applicable staff in line with existing procedures.

All Staff	All staff, including temporary and agency staff, have a responsibility to: • Keep appropriate records of their work in the CCG and manage those records in keeping with this policy and all related procedures. • Adhere to the information governance responsibilities, which include records management which are in all staff employment contracts. • Conduct themselves in accordance with the NHS Care Record Guarantee and Department of Health Records Management Code of Practice for Health and Social Care 2016. • Undertake information governance/ records management training in line with the requirements of their role. • Participate in any audits as requested. • Bring to their line manager areas of concern regarding records management including changes in practice and training needs. • Report incidents through the CCGs incident reporting process.
CSU Staff	Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures.
The Senior Information Risk Owner (SIRO)	The Senior Information Risk Owner (SIRO) has a responsibility to: • Oversee the development of an Information Governance & Information Risk Policy and Strategy and its implementation. • Take ownership of risk assessment process for information risk. • Review and agree action in respect of identified information risks. • Ensure that the Organisation approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff. • Provide a focal point for the resolution and/or discussion of information risk issues. • Ensure the Governing Body is adequately briefed on information risk issues. • Successfully complete strategic information risk management training at least annually.

5. Implementation

5.1 This policy will be available to all Staff for use in relation to the specific function of the policy.

5.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

7. Related Documents

7.1 Legislation and statutory requirements

- Cabinet Office (1958) *Public Records Act 1958*. London. HMSO.
- Cabinet Office (1967) *Public Records Act 1967*. London. HMSO.
- Cabinet Office (2018) *Data Protection Act* (2018)London. HMSO.
- Cabinet Office (1009) *Access to Health Records Act 1990.*London. HMSO.
- Cabinet Office (2000) *Freedom of Information Act 2000*. London. HMSO.
- Cabinet Office (2004) *Environmental Information Regulations 2004*. London. HMSO.

7.2 Related Procedures

- Information Labelling & Classification Procedure
- Information Asset Management
- Subject Access Requests

8. Monitoring, Review and Archiving

8.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

8.2.2　Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3　For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3　Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with the Department of Health Records Management Code of Practice for Health and Social Care 2016.

9. Equality Analysis

An equality impact assessment has been completed:

Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	Senior Governance Officer, NECS
Title of service/policy/process:	Records Management Policy and Strategy
Existing: √ New/proposed: ☐ Changed:	

What are the intended outcomes of this policy/service/process? Include outline of objectives and aims
This policy provides guidance to staff to carry out their corporate and personal record management responsibilities to support high quality patient care. The CCG records are part of the organisation's corporate memory, providing the evidence of actions and decisions and representing a vital asset to support daily functions and operations. It supports the organisation and staff in meeting their obligations in terms of legislation and national good practice guidance. It provides effective governance arrangements for records management, also known as 'information lifecycle management'. The policy compliments other Information Governance policies.

Who will be affected by this policy/service /process? (please tick)

☐ Consultants ☐ Nurses ☐ Doctors
√ Staff members ☐ Patients ☐ Public
☐ Other

If other please state:

What is your source of feedback/existing evidence? (please tick)

☐ National Reports ☐ Internal Audits
☐ Patient Surveys ☐ Staff Surveys ☐ Complaints/Incidents
☐ Focus Groups ☐ Stakeholder groups √Previous EIAs
☐ Other

If other please state:

Evidence	What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	N/A
Patient Surveys	N/A
Staff Surveys	N/A
Complaints and Incidents	N/A
Results of consultations with different stakeholder groups – staff/local community groups	N/A
Focus Groups	N/A
Other evidence (please describe)	N/A

STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
No impact identified
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
No impact identified
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self-perception.
No impact identified
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
No impact identified
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
No impact identified
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
No impact identified
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
No impact identified
Sex/Gender A man or a woman.
No impact identified
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
No impact identified
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
No impact identified
Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers
No impact identified

STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?
No engagement undertaken as this policy has received minor amendments only
Please list the stakeholders engaged:

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users of the policy?
☐ **Verbal – stakeholder groups/meetings**   ☐ **Verbal - Telephone**   ☐ **Written – Letter**   ☐ **Written – Leaflets/guidance booklets**   ☐ **Email** √ **Internet**   ☐ **Other**
If other please state:

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Tick to confirm you have you considered an agreed process for:
√ **Sending out correspondence in alternative formats.**   √ **Sending out correspondence in alternative languages.**   √ **Producing / obtaining information in alternative formats.**   √ **Arranging / booking professional communication support.**   √ **Booking / arranging longer appointments for patients / service users with communication needs.**
If any of the above have not been considered, please state the reason:

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
None identified.	

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
	N/A					

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
	N/A		

SIGN OFF

Completed by:	Alan Clement, Senior Governance Officer
Date:	June 2018
Presented to: (appropriate committee)	Executive Committee
Publication date:	July 2018

Records Management Strategy

1. Introduction

1.1 This strategy is an overarching framework for integrating all records management functions within the CCG. It sets out the requirements necessary for maintaining and for improving the quality, availability and effective use of records to meet the CCG business needs and identifies the actions for implementation.

1.2 The strategy should be read in conjunction with the Records Management Policy.

2. Scope

2.1 This strategy relates to all patient/service user and corporate records held in any format by the CCG as detailed in the Department of Health Records Management Code of Practice for Health and Social Care 2016.

3. Aims

3.1 The aim of the strategy is to establish records management as a corporate function of the CCG supported by CCG Information Governance arrangements as indicated by:

- A systematic and planned approach to records management covering records from creation to disposal.
- The promotion of efficiency and best value through improvements in the quality and flow of information, and greater co-ordination of records and storage systems.
- Compliance with statutory requirements.
- Awareness of the importance of records management and evidence of responsibility and accountability at all levels.
- Robust retention and disposal procedures.
- To move toward electronic record keeping in support of national guidance.

4. Key Elements

4.1 Responsibility and Accountability

- All staff should be aware of the need for accountability and responsibility in the creation, amendment, management, storage of and access to the CCG's records.
- There should be a clear chain of management accountability and responsibility for all records created by the CCG.

4.2   Record Quality

- Records created should be adequate, consistent and meet the statutory, legal and business requirements of the CCG.
- Records should be accurate and complete, in order to facilitate audit, fulfil the CCG's responsibilities, and protect its legal and other rights.
- Records management systems should ensure the validity and authenticity of records, for example, controlled access so that any evidence derived from them is credible and authoritative.

4.3   Management

- There should be systematic, orderly and consistent creation, retention, appraisal and disposal procedures for records throughout their life cycle.
- Records management systems should be easy to understand, clear and efficient in terms of minimising staff time and optimising the use of space for storage.

4.4   Security

- There should be systems which maintain appropriate confidentiality, security and integrity for records both in use and storage.
- Such systems should be robust enough to support the accuracy and authenticity of its records contents, and their evidential value.

4.5   Access

- There should be fast and efficient access to records for authorised staff.
- Access procedures should be effective in supporting subject access requests under the Data Protection Act 2018 and requests made under the Freedom of Information Act 2000.

4.6   Audit

- The performance of records management will be audited regularly and measured against agreed standards.

4.7   Training

- Training and guidance on records management responsibilities and operational good practice will be provided for all staff.

5. Implementation

5.1 The implementation of the strategy will be evidenced by the following action points which have been developed from the CCG Records Management Policy:

- An overall policy statement on how all records are to be managed.
- The endorsement of the policy by senior management.
- The dissemination of the policy to staff at all levels.
- The establishment of records management roles and responsibilities of staff at all levels to ensure the security, integrity and accountability of records.
- The provision of a framework for supporting appropriate standards, procedures and guidelines through CCG records management/ Information Governance arrangements.
- The use of monitoring mechanisms to assess compliance with appropriate standards, procedures and guidelines.
- Regular review of the policy.