IGP107 - Health Records Management and Keeping Standards Policy
Table of Contents

Why we need this Framework ................................................................. 3
What the Framework is trying to do ........................................................... 3
Which stakeholders have been involved in the creation of this Framework ............. 4
Any required definitions/explanations ....................................................... 4
Key duties .................................................................................................... 5
Framework detail ......................................................................................... 7
Training requirements associated with this Framework ..................................... 17
How this Framework will be monitored for compliance and effectiveness .............. 18
For further information ................................................................................ 18
Equality considerations ................................................................................ 18
Document control details ............................................................................. 18
**Why we need this Framework**

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

Record keeping is an integral part of all clinical practice. A patient’s health record should provide a complete history of events and evaluations, to aid diagnosis and treatment by any clinician who has a responsibility for that patient.

Records must be kept accurate to prevent wrong decisions, allow for clear interpretation of information and reduce delays in patient care.

Good record keeping also provides protection for the patient and clinical care staff in case of litigation or complaint.

**What the Framework is trying to do**

NHFT is committed to the systematic and planned approach to the management of all records from the moment they are created to their ultimate disposal and because of this has taken the decision to adopt both a records management policy for corporate and business records and a separate and specific policy on the management of patient health records.

This policy covers the management of clinical and patient records held by NHFT regardless of the media on which they are held. For the purpose of this policy, these are referred to as “Health Records”. This policy applies equally to paper based and electronically held records, unless otherwise specified.

This document sets out a framework within which the staff responsible for managing the organisation’s health records can develop specific local procedures and guidance to ensure that records are managed and controlled effectively and are commensurate with legal, operational and information needs.
Function of Records

Records are a valuable resource because of the information they contain.

Health records may be needed to:

- Support patient care and continuity of care
- Support evidence-based practice
- Meet legal requirements and regulatory requirements including requests from individuals under subject access provisions of the Data Protection and Freedom of Information Acts
- Assist clinical and other types of audits
- Support improvements in clinical effectiveness through research
- Support archival functions by taking account of the historical importance of material and the needs of future research
- Support patient choice and control over treatment and services designed around patients.

This Policy aims to:

- Make sure health records created by registered and non-registered health and social care staff employed by NHFT are accurate, timely, comprehensive and provide relevant detail in relation to the health care needs of each person who uses health and care services by NHFT
- Identify the responsibilities and duties of all health care staff in creating and maintaining accurate and contemporaneous health records
- Comply with legal requirements, NHS and professional codes of conduct.
- Minimise risk associated with poor health record keeping by defining minimal acceptable standards

Which stakeholders have been involved in the creation of this Framework

- Information Governance Forum
- IM&T Programme Board

Any required definitions/explanations

Data Protection Legislation


Record

A Record comprises of recorded information in any format e.g. digital or physical of any type, in any location (e.g. central database server, PC, filing cabinet, archive store), which is created, received, or maintained by NHFT in the transaction of its activities or the conduct of its affairs, and kept as unique evidence of such activity.

A Health Record is defined in Section 205 of the Data Protection Act 2018 as: (a) consists of data concerning health, and (b) 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.

Records management is the process of controlling records from their creation, usage, maintenance, and
storage, to their ultimate destruction or permanent preservation, and aims to ensure that:

- The record is present: that NHFT has the information that is needed to form a reconstruction of activities or transactions that have taken place.
- The record can be accessed: so that information can be located and accessed, and the current version identified.
- The record can be interpreted: that the record is legible and that the context of the record can be established: who created the document and when, during which business process, and how the record is related to other records.
- The record can be trusted: that the record reliably represents the information that was actually used in or created by the business process, and its integrity and authenticity can be demonstrated.
- The record can be maintained through time: that the qualities of accessibility, interpretability and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes in physical or electronic formats.

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

**Key Duties**

**Keeper of Public Records**
All NHS records are public records under the terms of the Public Records Act 1958, Section 3. Therefore all NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. This is carried out under the overall guidance and supervision of the Keeper of Public Records, who is answerable to Parliament.

**Chief Executive**
Ultimate responsibility rests with the Chief Executive of NHFT and delegated senior managers of NHFT who are personally accountable for records management within the organisation. In addition, NHFT is also required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and/or obsolete services.

**Data Protection Officer**
Has responsibility for providing guidance on records management issues where they relate to processing activities under GDPR.

**IM&T Programme Board**
The IM&T Programme Board will oversee the review of policy.

**Information Governance Forum**
The Information Governance Forum will oversee the operational management of information processing initiatives, i.e. Information Governance within NHFT.

**Nominated Records Management Leads**
Within each department/unit they have responsibility for safeguarding the records within their department/unit, including the safekeeping, accessibility, tracking and retention of records in line with national and local policy, the transfer of those records selected for permanent preservation, and the timely destruction of records no longer required.

**All Managers (Clinical and Non-clinical)**
Have the responsibility to implement and monitor the operation of this policy within their functional
areas. Ensure that staff follow and adhere to this policy at all times. Ensure that staff are given opportunities for appropriate records management and standards training and awareness. Ensure the safe and secure care and storage of vital records within their remit. Ensure that processes and procedures are in place to facilitate effective records management. Identify records management leads within their functional areas.

**IM&T and nominated system owners**

Are responsible for:

- Monitoring and ensuring systems are operating in accordance with system policies and procedures.
- Creating and maintaining access rights and appropriate levels of security.
- Providing systems administration support.
- Ensuring electronic records are backed up regularly to safeguard against the loss of information due to equipment malfunction or human error.
- Ensuring that information is not jeopardised because of changing technology or deterioration of storage media.
- Creating/maintaining shared network and individual workspaces in accordance with organisational needs.

**Information Asset Owner**

The role of the Information Asset Owner is to understand and address risks to the information assets they manage and to provide assurance to the Senior Information Risk Owner (SIRO). They must also:

- Lead and foster a culture that values, protects and uses information for the success of the organisation and benefit of its patients
- Understand the Organisation’s plans to achieve and monitor the right NHS IG culture, across the organisation and with its business partners
- Take visible steps to support and participate in that plan (including completing own training)
- Knows what information the Asset holds, and what enters and leaves it and why.
- Maintains understanding of ‘owned’ assets and how they are used.
- Approves and minimises information transfers while achieving business purposes.
- Approves arrangements so that information put onto encrypted, portable or removable media like laptops and CD-ROM are minimised and are effectively protected to NHS IG standards
- Approves and oversees the disposal mechanisms for information of the asset when no longer needed
- Ensures decisions on access are taken in accordance with NHS IG Standards of good practice and the policy of the organisation.
- Knows who has access and why, and ensures their use is monitored and compliant with policy
- Understands the organisation’s policy on access to and use of information
- Checks that access provided is the minimum necessary to satisfy business objectives
- Receives records of checks on use and assures self that effective checking is conducted regularly
- Understands and addresses risks to the asset, and provides assurance to the SIRO
- Conducts quarterly reviews of information risk in relation to ‘owned’ assets
- Makes the case where necessary for new investment or action to secure ‘owned’ assets
- Provides an annual written risk assessment to the SIRO for all assets ‘owned’ by them
- Ensures the asset is fully used for the benefit of the organisation and its patients, including responding to requests for access from others
- Considers whether better use of the information is possible or whether information is no longer required
- Receives, logs and controls requests from others for access
Senior Risk Information Officer (SIRO)
The SIRO is representative at board level and is responsible for ensuring effective management of information risks throughout the Trust.

Caldicott Guardian
Has responsibility for reflecting patient’s interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

All NHFT Staff (including registered and non-registered clinical staff)
All NHS employees have a “records management guardianship” role especially for any records that they create, but also generally for any records that they use in the course of their duties. This includes completion of training to meet any mandatory or additional identified learning and development needs required to fulfil those responsibilities all staff;

• are responsible in law for any records they create and use
• must be aware that any records they create are not their personal property, but belong to NHFT
• should understand their responsibilities under Data Protection Legislation when using or communicating personal data and information
• should share records and the information they contain only in accordance with professional standards, local policy and information sharing protocols

Framework detail

Process for the Creation of a Health Record
The main Health Record and any additional Health Records should be marked with the NHS Number as primary identifier along with the appropriate local identifier where applicable.

Creation of the health record
Once a new patient has been received into a Trust service, if a record does not exist, a unique Health Record will be created by the relevant clinician and the treatment process will begin.

Paper and electronic records
Where documents are created and filed in both electronic and paper format the indexing/cataloguing naming conventions must mirror each other. The procedure stated in this policy, therefore, relates to both paper and electronic records.

Defining the main record

• Electronic Patient Record (Paperless systems)
The implementation of fully Electronic Patient Record (EPR) systems has reduced the reliance on paper based health records. Where Electronic Patient Records are in use they are considered to be the main health record and must contain a reference to complete and up to date personal demographic information and a record of all relevant clinical interventions with the patient. It should be noted that even a fully implemented EPR has paper-light content.

• Paper Health Record
Where an electronic patient record system has not been fully implemented, the paper based health record will be considered to be the master record and must contain a complete and up to date record of all relevant clinical interventions with the patient. Every page of a paper health record, regardless of whether they are created or printed
from an electronic system, or received, must contain the relevant patient identifiers and confidential markings.

**Minimum data set**

All health records will contain the minimum data set of personal details in addition to any health professional record keeping standards. This will include but is not limited to the following:

- Full Name (including first name, last name, known as, and title)
- Address, Postcode and Telephone Number;
- Gender
- Ethnic Origin
- Date of Birth
- Communication Need;
- NHS Number
- GP Practice Address and Telephone Number.

**Audit trail**

All Health Records will include an audit trail comprising of date created, and details of all additions, changes, deletions and viewings. Audit trails capture the life cycle of all patient health records that are created in line with Trust policy.

**Consent**

Patients should be informed that a health record is to be created and their consent preferences obtained.

Staff must also advise patients who can access that record where it will be shared along with the purpose for access. This should be clearly recorded as a separate entry in the patient health record.

If a patient wishes to dissent from an electronic record advice should be sought from the Information Governance Team Who will advise on the legal basis for holding information relating to healthcare

**Registration**

Where it is evident that the patient is not registered on the relevant system, then the team who have received the referral will register the patient within the relevant system. Details of the patient will be collated from the referral and, if possible, supplemented or backed up by information gained directly from the referrer or patient themselves.

**Creation of health record Paper files:**

- Exemptions to the creation of Paper Files:

  Not all systems require creation of paper health record files; full Electronic Patient Records (EPR) record all events within the electronic system, therefore paper records should not be held separately from the master record and must be scanned into the EPR.

  Staff must also ensure that electronic records are matched to the spine, where able, to ensure that duplication of electronic records is also avoided.
• Paper Health Record Files (no EPR deployed to the service):

Paper health records will be created by the team receiving the referral for all new patients registered. If there is a clinical need to create a new paper health record file, i.e., the paper record has been defined as the main health record, and no existing paper health records exist, follow the steps as outlined below.

• Process to Avoid Duplicate Main Health Record Paper Files:

As each referral is received by the Trust, the team receiving the referral will undertake a search for all relevant existing paper health files to avoid creation of duplicate records, and to identify/define the main health record as the most current volume and to ensure continuity of care.

• Process of Registering Health Records on a Tracking System

All individual health record paper file volumes must be entered/registered on the relevant trust patient document tracking system.

Health records standards and completeness Format

All health records should be written in terms that the patient (or their representative) can understand, and be completed where possible with their involvement.

All health record entries must be recorded in full i.e. without abbreviations/acronyms.

All Health records should follow Trust policy for clinical coding and systems data quality.

Where an electronic system is not available the paper records created must follow the standardised filing structure.

All health records must be written clearly and legibly.

Health record forms should be completed in full; where there are sections left blank this should be noted as intentional in order to be considered valid. For forms on SystmOne the below disclaimer should be used for all templates.

‘All fields in this template have been considered. Fields left blank are to avoid inappropriate coded entries into the clinical record’

All health record entries must be completed in dark ink which is readable on any printed, scanned or photocopied version – green or red ink should not be used for health records. The exception to this will be where pharmacy staff needs to clarify a prescription, pharmacists will write in red ink and pharmacy technicians will write in green.

Content

NHFT provides a wide range of healthcare services therefore processes and documentation will differ, however, all health records should contain information regarding referral, assessment, planned and agreed interventions and discharge. Healthcare staff must look to their operational policies, protocols and clinical policies for further guidance with regards to specific requirements and expectations.
Deletions and Corrections

A health record entry must only be removed or deleted when approved by the Trust Caldicott Guardian and only in situations where the entry is likely to be damaging to an individual. Otherwise, corrected entries can be made which must include an audit trail of the correction.

If an electronic record entry needs to be corrected then the procedure for the particular system in use will be followed.

If a written entry needs to be corrected, this should be done with a single line through the text in order that the original record can still be read, as well as the signature, name, designation, date and time that the correction was made.

Contemporaneous Recording

All health record entries, including alterations or corrections, must be clearly dated and timed using a 24 hour clock, to reflect the date and time of entry.

All health record entries should be completed as soon as possible after an event has occurred and before the member of staff goes off duty, in order that records are consecutive.

If there is a valid reason for a health record to be made retrospectively, the member of staff must ensure that the time and date of the event referred to is also recorded.

Relevance and Usefulness

All health record entries should evidence:

- Problems that have arisen and action taken to rectify them;
- The care planned, decisions made, care delivered and information shared
- The actions agreed with the patient (or their representative)
- If care is shared across teams/ patient/ services, clarity should be provided on who has responsibility for each relevant part.

Clinical alerts and warnings should be recorded according to relevant protocol and/or guidance (allergies; risk warnings; DNACPR)

Health records should not include:

- Unnecessary abbreviations or jargon
- Meaningless phrases, irrelevant speculation or offensive subjective statements;
- Irrelevant personal opinions about the patient (or their representative)

Countersigning

All health record entries made by student health care professionals are to be countersigned by a registered health professional.

All health record entries made by support staff must be countersigned by the delegating registered health professional until the member of staff is assessed as competent to record.
health records independently

**Quality Assurance**

As a core element for clinical practice, health record keeping should be an integral part of reflective practice within clinical supervision

Clinical audits of health record keeping standards should be undertaken quarterly by clinical teams as part of NHFT’s Quality Schedule. Audits comprise of a review of a sample of health records to assess the content of the record against the standards as set out in this policy

**NHS Number**

There are four major principles:

- The NHS number will be included as a patient identifier on all systems and documents which include Patient Identifiable Data
- The NHS number will be the “first choice” for searching electronic patient records
- All practical attempts should be made to determine the NHS number before or at the start of an episode of care, but if this is not possible, tracing should be performed as early as possible in the episode.

For more guidance see NHFT guidance documents on finding the NHS Number.

**Records Retention and Destruction**

- **Keeping records secure**

  Maintaining the integrity of information is important for all records and this includes keeping records secure. More specifically maintaining the security and confidentiality of information is vital for clinical and patient records in order to protect patient and staff confidentiality.

  A sensible balance needs to be maintained between the needs for accessibility and convenience of records and the security and confidentiality of records.

  Record files and encrypted, portable equipment should be stored under lock and key when not actually being used. Staff should not leave computers, medical notes or files containing confidential information unattended in cars or in easily accessible areas. Staff should not normally take health care records home, and where this cannot be avoided, procedures for safeguarding the information effectively should be agreed by the relevant Director concerned.

  In addition all electronic health care record systems must be secure and protected by Smartcard access, or by login ID and password, or similar access control mechanisms where Smartcard is not available.

- **Storage and security – Paper records in the absence on an EPR**

  The location and storage of paper records is important because it can impact on their availability and their long term preservation. Records must be stored in locations which are easily available to any member of staff who may need to retrieve
them. They must also be stored somewhere which will ensure they last for as long as they are required, which in some cases may be many years.

When a paper record is in constant or regular use, (i.e. An Active Record) or is likely to be needed quickly, it makes sense to keep it within the department/unit responsible for the related work.

All records that are not Active Records must be stored locally for no longer than 3 months.

Therefore storage equipment for Active Paper Records/Current Paper Records will usually be adjacent to users (e.g. in a desk drawer or nearby filing cabinets).

Where an EPR is in use:
Once paper records are scanned onto the relevant EPR the hard copy can be securely destroyed. This is providing the scanned copy is of a suitable quality that it accurately reflects the original.

**Process for Retention and Disposal**

Under Data Protection Legislation, all health records may be subject to disclosure even if they have been held outside of the Department of Health retention schedules by NHFT.

Therefore it is important that the retention and disposal of records – defined as the point in the records lifecycle when they are either transferred to an archive or destroyed is undertaken in accordance with clearly established procedures, local and national retention schedules and enforced by appropriately trained and authorised staff.

Records are required to be kept for a certain period either because of statutory requirement or because they may be needed during this time. Records can be kept for longer than this if NHFT decides to do so – but this decision needs to be recorded locally within the organisation’s own retention schedule.

Records should be retained for as long as they are required and no longer. Records containing personal information are subject to Data Protection Legislation. The fifth principle of the GDPR, states that “personal data shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed”

Minimum retention periods are laid down in the NHS Records Management Code of Practice. This code will form the basis of NHFT local retention schedules which will be developed over time with local decisions on retention recorded against the national schedules and available on the intranet.

**Departmental Records Management – Paper Records**

A review of departmental record collections must be undertaken at least annually to determine which records should be retained, archived or for disposal to be arranged.

It is useful to think of records in the following categories:

- Active Records
- Semi-Active Records
- Expired Records
The points to consider include:

- Are the records still required for the function for which they were created?
- Do the records have any social, scientific, operational, historical, or legal significance?
- Has local clinical need been considered?
- Has the value of the records for long-term research purposes been assessed?
- Is an appropriate place of deposit available?
- Have all interested parties been consulted?

This table indicates the appropriate actions to take during this review.

<table>
<thead>
<tr>
<th>Category</th>
<th>Meaning</th>
<th>Action for Electronic Records</th>
<th>Action for Physical Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active records</td>
<td>Records that are current and referred to frequently</td>
<td>Retain and maintain these records in their current digital format</td>
<td>Retain and maintain these records in a secure storage area close to users</td>
</tr>
<tr>
<td>Semi-active records</td>
<td>Records that are referred to infrequently, and that are rarely required for current use</td>
<td>No specific action - retain the records in their current form</td>
<td>These records could be moved to an archive store until they exceed their retention period</td>
</tr>
<tr>
<td>Expired records</td>
<td>Records that have not exceeded their retention periods</td>
<td>Mark these records as expired (and consider migration to an annexe database)</td>
<td>Move these records to an archive store (if not already in one) and mark them as expired</td>
</tr>
<tr>
<td></td>
<td>Records that have exceeded their retention periods</td>
<td>Mark these records as expired (and consider migration to an annexe database)</td>
<td>Review archiving arrangements and provide details to the Information Governance team for disposal to be considered</td>
</tr>
</tbody>
</table>

Semi-Active and/or Expired records need to be relocated away from the workplace to a dedicated archive store.

NHFT provides such facilities for both health care and corporate/business records.

NB.: Boxes can be retrieved from the archive store within three days. However every stored box carries a cost, as does every box retrieved and returned to the archive.

If this information is required more than once a year then archive storage may not be the most appropriate. In turn expired records must be:

- Destroyed OR
- Retained for specific purposes OR
- Permanently preserved

**Process for Destruction**
The destruction of Health Records must be approved by the department line manager and submitted to the Information Governance team for final approval prior to destruction.

Once the decision to destroy health records has been approved, the record must be destroyed in all formats held by the Trust, such as paper or electronic.

The methods used for destruction of confidential and person identifiable information, both paper and electronic, should ensure that the confidentiality of individuals is fully maintained throughout the process of destruction.

Under no circumstances will un-shredded person-identifiable information be sent for recycling.

All confidential paper waste must be disposed of by using an approved cross shredder (approved to national standards) and ‘Confidential Waste’ bags, or using a secure shredding company.

**Process for Archiving Records**

All records must be kept in line with Trust retention schedules. For additional information please see IGPr001 Procedure for Archiving

**Process for Retention of records for Specific Purposes**

Records may be retained for specific purposes after their retention period has expired if they are deemed valuable for specific purposes, e.g. research.

Such retention must not contravene Data Protection Legislation. This usually means anonymising records by removing any data by which an individual may be identified. However, if records are kept for litigation purposes, then person-identifiable data may have to be retained.

All records retained for specific purposes should be clearly marked on the record with the following minimum information:

- Reason
- Source of authorisation
- Date of the decision
- Review date.

**Process for Permanent Preservation**

Public records should not normally be kept for longer than 30 years calculated from the last date of intervention without being transferred to a formal Place of Deposit.

Certain records may be deemed valuable (for example, because they have historical interest), and should therefore be sent for permanent preservation to the Public Record Office Place of Deposit as show below:

The County Archivist
Records Office
Wootton Hall Park
Northampton
Other Considerations:

Community Diaries

Community diaries are permitted for use if kept securely at all times. It is advised that all, or as much information as possible, should be anonymised. Only the minimum information necessary should be entered into the diary to minimise any potential personal data loss or incident. Diaries should also be kept in line with Trust retention schedules.

Process for Reporting Records Identified as Lost or Misplaced: Active Paper records

If health records are lost or misplaced the following procedures must be adhered to.

- Staff must advise their line manager/service manager as soon as possible.
- An Incident Report must be completed as soon as possible in line with Trust policy
- The patient must be advised of the incident in writing and offered an opportunity to discuss with the clinician or service manager should they have any queries or concerns
- An appointment must be arranged with the patient to complete an assessment form within one working week
- The clinician must clearly note in the replacement notes that the record is a replacement record stating the date the record was noticed to be missing.
- If the record relates to a child the organisations named nurse or named doctor must be notified so that records can be checked for any current or previous child protection issues.
- If there are, or have been, any child protection issues the clinician must contact the Child Protection Team for copies of any notes or minutes regarding the child.
- The named nurse or named doctor must also be notified if the notes of a parent, where there is a current or suspected Child Protection Issue, go missing
- In the eventuality that the old notes are found the two sets of notes need to be merged, with notes filed in a chronological order and any spaces crossed through.

An Incident Form should be completed as soon as possible and sent to the Risk Management Team. The Risk Management Team should monitor the frequency of such incidents and the circumstances leading up to the incident to ensure effective patient care.

Verbal orders

Instructions by telephone to a practitioner to administer a substance not previously prescribed are not acceptable.

In exceptional circumstances, where medication (NOT including Controlled Drugs) has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology such as by fax, email or electronic record may be used. When using fax or email information governance issues must be taken into consideration.

A verbal order is not acceptable on its own. A written prescription/direction (copy of fax/email or entry in electronic record) to administer must be stapled to the patient’s existing medication chart. This should be followed up by a new prescription signed by the prescriber who sent the fax/email or SystmOne entry confirming the changes within normally a maximum of 24 hours (72 hours maximum –
Bank Holidays and weekends). In any event, the changes must have been authorised (via fax/email/SystmOne entry) by a registered prescriber before the new dosage is administered. A pharmacist or pharmacy technician may receive a verbal order from a prescriber to alter or add a prescription item where it is impractical for the amendment to be made by the prescriber (e.g. if the chart is in pharmacy). Such alterations must be signed by the person taking the verbal order. The pharmacist or pharmacy technician must read the alteration or addition back to the doctor who must then confirm it. The prescriber must sign any new prescription within 24 hours.

Wherever possible the prescriber should make required amendments to prescriptions in person. It is, however, recognised that in certain situations patients may deteriorate rapidly and faxed or emailed prescriptions for new medications may be necessary to avoid compromising patient care. These should be followed up within 24 hours (72 hours maximum) with a hard copy. All prescribing decisions must be recorded in the clinical record contemporaneously.

**Important:** It is the prescriber’s responsibility to ensure clinical assessment is undertaken and allergy status checked prior to prescribing.

Verbal orders or faxed prescriptions for Controlled Drugs are NOT allowed, as legal requirements would not be met.

**Records in the Home**

Normally there should be only one set of records per person - no duplicate or ‘shadow’ files should exist. However, there are exceptions to this in services such as Child Health or District Nursing, where a summary remains in the patient’s home, whilst the main record is contained within the EPR system.

It is the responsibility of each clinician to ensure that when, and for whatever reason (e.g. if judged necessary to meet the needs of an individual client group), they decide to keep a second separate record, to ensure that other clinicians providing care are kept informed of the details of the second record by the provision of regular summaries during care, plus a final summary on completion of any one episode of care.

At the completion of any one episode of care a summary of the treatment and care provided must, with the patient’s permission, be sent to the patient’s General Practitioner. Patient held records will be retrieved and archived with the exception of the Child health Red Book.

**Record Sharing Between Organisations**

Sharing data (including records) across and between organisations can be a complex process as there is no single source of law regulating the collection, use and sharing of personal information.

Information exchanges must always take place within the legislative framework, essentially Data Protection Legislation; Human Rights Act 1998; Children’s Act 2004; the Crime and Disorder Act 1998 and various statutory provisions and common-law rules for exchange or prohibitions on disclosure.

Where medical records are exchanged between organisations the appropriate consent will be sought and obtained from the patient and any relevant third parties before transfer, unless there is another legal basis to do so.

**Subject Access Requests**
Data Protection Legislation provides data subjects and their representatives with subject access rights to their personal information. In addition the Access to Health Records Act 1990 provides a similar legal right to deceased patient’s records.

Process for Archiving and Retrieval of Paper Records

All records created by NHFT must be arranged in a logical, appropriate record-keeping system that will enable quick and easy retrieval of information.

Each department/unit must maintain a detailed record following the Trust approved procedure IGPr001 to enable the ability to manage these records. Where paper records are required to be retrieved from Archive the Information Governance Team should be contacted. Any records retrieved from archiving and held locally should be secured and returned to the registered archive location as soon as possible.

Process for Transporting Paper Records

Health records should be transported in a secure manor at all times using tamper evident envelopes, secure encrypted email or electronic device, or Safe Haven procedures. Paper health records should be tracked in and out of the department.

Internal porters or manual transfer can be used if the Health Records are put into tamper evident envelopes. If medical records are being sent externally through the post, they must be sent via Royal Mail recorded delivery.

If transfer is to take place via electronic device this must be Trust approved encrypted equipment.

Training requirements associated with this Framework

Mandatory Training

Information Governance training has been integrated into NHFT’s induction programme for all new staff. For existing staff, an ongoing programme of refresher training will be delivered as part of NHFT’s Information Governance work programme. All staff members must complete Information Governance training before access is given to patient records. This training must be completed annually. Additional campaigns and awareness raising will be undertaken as appropriate.

Specific Training not covered by Mandatory Training

It is the responsibility of all managers to ensure attendance at induction and training programmes and to obtain feedback from staff regarding the knowledge and understanding they have obtained.

Individuals have an obligation to seek training, advice and support where uncertain in order to improve information practices appropriately.

Ad hoc training sessions based on an individual’s training needs as defined within their annual appraisal or job description.
How this Framework will be monitored for compliance and effectiveness

This framework will be made available to the Public through the Trust Internet site in supporting documentation and upon application.

New employees will be made aware of this policy through the Induction process.

Information Governance activity will be reported monthly in Information Governance Highlight Reports to the IM&T Programme Board.

Monitoring of compliance with the records keeping standards outlined in this policy should be through staff appraisal and supervision.

For further information

Please contact the Information Governance Team by emailing information.governance@nhft.nhs.uk

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Framework changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of ‘protected characteristics’ including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Framework and identified that the advice and guidance service offered to patients and staff and reported IG incidents will be monitored.

Document control details

<table>
<thead>
<tr>
<th>Author:</th>
<th>Information Governance Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by and date:</td>
<td>The Information Governance Planning Group Trust Policy Board – 25/06/2019</td>
</tr>
<tr>
<td>Responsible committee:</td>
<td>IM&amp;T Programme Board</td>
</tr>
<tr>
<td>Any other linked Policies:</td>
<td>IGIS01 – Use of Information and Communications Technology Policy IGP107</td>
</tr>
<tr>
<td>Framework number:</td>
<td>V7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Date Ratified/Amended</th>
<th>Date of Implementation</th>
<th>Next Review Date</th>
<th>Reason for Change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>25/06/19</td>
<td>26/06/19</td>
<td>25/06/22</td>
<td>Structured in approved format. Legislation updated and content updated for relevance.</td>
</tr>
</tbody>
</table>