

1.0 Introduction

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 practice 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.

2.0 Source/Ref:

- NHSE Policy
- NHSE Code of practice on records management
- HSCIC Took kit
- Connecting for Health

3.0 Detail

3.1 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 confidential disposal or archival preservation.

3.2 In this policy, 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.'

3.3 The aims of our Records Management System are to ensure that:

- records are available when needed - from which the practice is able to form a reconstruction of activities or events that have taken place;
- records can be accessed - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;
- records can be interpreted - the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;

- records can be trusted – 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;
- records can be maintained through time – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- records are secure - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- records are retained and disposed of appropriately - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
- staff are trained - so that all staff are made aware of their responsibilities for record-keeping and record management.

3.4 Pimlico Health @ The Marven has Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The practice will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The Data Protection Act 1998;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality; and
- The NHS Confidentiality Code of Practice.
- and any new legislation affecting records management as it arises

3.5 Retention and Disposal Schedules

It is a fundamental requirement that all of the Pimlico Health @ The Marven records are retained for a minimum period of time for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's business functions.

Pimlico Health @ The Marven has adopted the retention periods set out in the Records Management: NHS Code of Practice. The retention schedule will be reviewed annually.

3.6 Records Management Audit

Pimlico Health @ The Marven will regularly audit its records management practices for compliance with this framework.

The intent of the audit is:

- Identify areas of operation that are covered by the practice policies and identify which procedures and/or guidance should comply to the policy;
- Follow a mechanism for adapting the policy to cover missing areas if these are critical to the creation and use of records, and use a subsidiary development plan if there are major changes to be made;
- Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance; and
- Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

3.7 Training

- All practice employees will be made aware of their responsibilities for record-keeping and record management through generic and specific training programmes and guidance.
- This is part of new employee induction period training, and all contracted staff will continue to carry out on-going training.

3.8 Review

This policy will be reviewed every two years (or sooner if new legislation, codes of practice or national standards are to be introduced).