Torbay and Southern Devon Health and Care NHS Trust

Information Management Policy

Date: February 2015

Partners in Care

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Document Information

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Management of Information Group		11 February 2015	
Links or overlaps with other strategies/policies:			
Information Governance Framework/Policy			
Website Management Policy			
Data Protection Policy			
Records Management Procedure and associated guidance including Protective Markings, Version Control, Personal Files, Retention & Disposal Schedule			
Information Asset Policy			
NHS Number Policy			
Staff Code of Confidentiality			
Safe Haven Procedure			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
V2	Final	April 2013	To include information from the Strategy	Carole Self
V3	Final	February 2015	Review of documentation and refresh of links and contact details.	Management of Information Group

Contents

1. Introduction

1.1 High quality information underpins the delivery of high-quality evidence-based health and social care, and many other key service deliverables. Information has most value when it is complete, accurate, relevant, accessible and timely (CARAT).

1.2 Effective information management systems[1] recognises that information has a lifecycle which needs to be managed to ensure that the *right information,* is with the *right person,* at the *right time* to support:

- day to day business which underpins the delivery of integrated care;
- individual choice and control over treatment and services designed around service users;
- quality and safety of care for our service users;
- evidence based good practice;
- sound administrative and managerial decision making, as part of the knowledge base for NHS services;
- our legal requirements, including requests for information under Data Protection Act, Freedom of Information Act and Environmental Information Regulations;
- effective use of resources;
- reputation of the Trust.

1.3 This document sets out the Trusts overarching framework for improving the quality, availability and effective use of information within the Trust. This policy is supported by the Records Management Procedure and a wide range of guidance which can be found on iCare (Trust's intranet). A current list can be found in Appendix 1. This document forms part of the Information Governance Framework.

1.4 This document relates to the following information assets (systems) and the information contained within in the formats outlined in Appendix 3.

- Management systems – finance, HR, commissioning
- Clinical systems – community services, general practice systems, acute and provider systems
- Specialist applications, client management and risk management
- Statistical and performance analysis/prediction systems
- Communication and organizational tools – directories, web services,
- Systems for information sharing, collation and analysis

1.5 Appendix 4 outlines a list of national and local programmes, initiatives, standards and frameworks that have a direct or indirect impact upon records management. This list is not exhaustive.

1.6 A list of information management terms and their definition is included in Appendix 2.

[1] Information management systems include shared drives, iCare, website, PARIS, paper filing systems, etc

2 Policy Statement

2.1 Torbay and Southern Devon Health and Care NHS Trust (the Trust) Board is committed to ensuring that all Trust data is 'fit for purpose' at all times and provided on a 'right first time' basis through:

- a systematic and planned approach to records management covering records from creation to disposal;
- 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 information and the need for responsibility and accountability at all levels; and
- appropriate archiving of records.

2.2 The benefits to the Trust are:

- Time saved both in filing and in retrieval of information;
- Decision making and operations are properly supported and informed by relevant information;
- Record storage is more cost-effective because redundant records can be removed from filing and server space;
- Records are created and managed in compliance with and as required by legislation, standards, regulations and good practice- see appendix 3 for further information;
- Accountability is demonstrated because the records provide reliable evidence of policy, decision making and actions/transactions;
- Duplicates and versions are removed as soon as possible;
- Records which the organisation judges to be no longer required are regularly and securely destroyed and the details documented;
- Increased customer satisfaction;
- More proactive in sharing information and good practice.

3 Roles & Responsibilities

3.1 The Chief Executive has appointed the **Senior Information Risk Officer** with the responsibility for co-ordinating, publicising and monitoring the implementation of the Information Management Framework.

3.2 The **Caldicott Guardian** is responsible for approving and ensuring that national and local guidelines and protocols on the handling and management of personal and sensitive information are in place.

3.3 Each **Director** has the overall responsibility for the management and quality of the data within their directorate.

3.4 **Information GovernanceTeam** is responsible for

3.4.1 ensuring that systems and processes are in place to manage all Trust information and to report regularly on progress against the Information Governance Toolkit to the Management of Information Group;

3.4.2 to provide advice, information and support to all staff through personal contact, team meetings, *i*Care, staff bulletins and training on information management and data quality.

3.4.3 Holding and keeping up to date the Information Asset Register which provides the Trust will information on major and minor assets that hold data in particular personal and sensitive data.

3.5 The **Integrated Governance Committee** will monitor and review all aspects of the systems in place as a basis for establishing significant information that should be presented to and dealt with by the Board.

3.6 The **Management of Information Group** which covers a wide range of IT and Information Governance topics will monitor progress against the Information Governance yearly work plan; the relevant requirements of the Information Governance Toolkit; Care Quality Commission Outcome 21 and receive regular reports on information risk.

3.7 The **Effectiveness & Audit Committee** will facilitate the implementation of care record keeping audits across both paper and electronic records for all areas of the Trust.

3.8 The **Risk Co-ordinators Group** will monitor risks to information systems and report as and when necessary areas of concern to the Management of Information Group and/or SIRO.

3.9 **Managers** are required to ensure:

- their staff are adequately trained and adhere to all relevant policies, procedures/guidelines;
- information is complete, accurate, relevant, accessible and timely (CARAT);
- staff are identified to undertake the role of Records Manager and/or Information Asset Owner within each area with their responsibilities clearly defined and assigned.

3.10 **Information Asset Owners** are responsible for ensuring

- staff accessing the information systems are fully trained and supported to ensure the relevance, accuracy, timeliness and quality of the data held;
- local procedures/guidelines are developed, implemented and monitored on a regular basis which will include access, duplicate records, removal of data/records, etc;
- report any risks identified within their systems to the Risk Co-ordinators Group or the Records Management Group.

3.11 **Employees** are responsible for

- any records they create or use in the course of their duties;
- ensuring data is complete, accurate, relevant, accessible and timely (CARAT);
- ensuring data contained in patient/client's records follows the SOAPE method (subjective, objective, assessment, plan and evaluate);

- reporting any incidents relating to quality, completeness, accuracy, relevance and security of data (lost, stolen, misplaced) through the incident reporting process;
- Returning all records to the department on transferring within the organisation or on leaving the organisation;
- Only accessing information to which they have a legitimate business reason.

4 Types of Records

4.1 "A NHS record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of work of NHS employees – including consultants, agency or casual staff" (*Records Management: NHS Code of Practice*).

4.2 All data contained within a care record or a corporate record as outlined in Appendix 3 is covered by this policy.

5 Data Quality

5.1 All data held on the Trust's computer systems must be valid and where codes are used, these will comply with national standards. The Trust will act on external data quality reports. Where available, validation routines will be applied, at the point of data entry, to ensure maximum accuracy.

5.2 When issues surrounding the quality of data are highlighted, relevant staff will be made aware of any changes that a re required of them. It is the Trust's intention that, wherever possible data will be corrected at sources.

5.3 Effective arrangements will be in place to ensure changes to national or local data standards are reflected in the Trust's policies and procedures. The Trust will ensure that there are clear and accurate data definitions in place to support the data collection process.

5.4 The Trust's main electronic care record system is PARIS and the Performance Team will run reports to identify missing and incorrect data. This information will be handled by the Team and disseminated to managers for action as appropriate.

5.5 In order to protect data as far as possible, the Trust will implement and utlise the NHS number on all data collection systems that hold care records. For further details on NHS number please refer to the NHS Number Policy.

5.6 There are many aspects to good quality data but the key principles for all records are complete, accurate, relevant, accessible and timely (CARAT). In addition for care records: subjective, objective, assess, plan and evaluate (SOAPE).

6 Filing Plans

6.1 Filing plans for both electronic and paper records are at the heart of information storage and retrieval activities. The establishment of a coherent filing system/plan provides for faster and systematic filing, faster retrieval of information, greater

protection of information and increased administrative stability, continuity and efficiency.

6.2 It needs to be designed to ensure that the system supports business processes and is easily understood and can be used effectively by relevant staff.

6.3 Appropriate controls should be built into filing systems to capture and identify accurately information required by the Trust.

6.4 Electronic files should be located in a safe and secure area which is backed up on a regular basis and password protected.

6.5 Paper filing systems should be located in an area with adequate security, fire protection and away from bright light or risk of damage from water.

6.6 Each Department/Team (including finance, estates, human resources, etc) of the Trust should have in place a process for documenting its activities in respect of information management. This process should take into account the legislative and regulatory environment in which they operate.

6.7 Information on how to set up a relevant file plan is contained in the Records Management Procedure, which can be obtained from the Trust's website.

7 Record Creation

In most cases the way individuals do business results naturally in the creation of records, including emails. Further information on how to create and manage records is included in the Records Management Procedure and additional guidance on iCare.

8 Duplicate Records

8.1 It is Trust policy to avoid duplication wherever possible and its aim is to have one single electronic record per patient/client. The use of the NHS number is key to this aim.

8.2 All systems should have a clear system in place for identification of duplicate records and the process for removing them.

9 Records Storage

9.1 Electronic documents should kept safe and secure and in accordance with the Trusts Information Security and Information Asset Policies and procedures.

9.2 Electronic records should be saved where they are accessible to those that need to access the information, this includes email.

9.3 Paper records must be kept safe and secure and when a room containing records, in particular confidential, personal and/or sensitive information is left unattended, it should be locked. A sensible balance should be achieved between the needs for security and accessibility.

9.4 If the need arises for personal identifiable information to be moved from the building, then all reasonable steps must be taken to ensure that the information is kept safe and secure whilst in transit and/or stored overnight. Information should not be left in cars overnight. Further information can be found in the Staff Code of Confidentiality which is available on the Trust's website.

9.5 Records should only be held in personal possession, e.g. car, home for the absolute minimum time possible and kept it line with the Staff Code of Confidentiality, which is avaible on iCare. Colleagues should be alerted to any records removed from the workplace to ensure their whereabouts are known at all times.

10 Retention and Deletion

The Trust's Retention & Disposal Schedule provides clear guidance for staff on how long records should be kept, how to archive and dispose of both paper and electronic information. Further information to support staff will be made available through the Information Governance pages on iCare.

11 Training and Awareness

11.1 Training and development of staff is key to the achievement of high standards of information management and data quality. The Trust will therefore ensure that the following principles are met in order to achieve this:

11.2 Records management and data quality will be included in all mandatory information governance training on an annual basis as well as induction in accordance with the Trust's Training Need Analysis.

11.3 Training will be provided to staff through the Information Asset Owner on information management systems that they use and/or manage.

11.4 Additional training will be provided by the Information Governance Team as and when identified to improve the quality of record keeping.

11.5 The Information Governance Team will provide advice/support on an individual basis, to teams as required and by providing up-to-date guidance and resources on iCare.

12 Monitoring, Auditing, Reviewing & Evaluation

12.1 Information Management will be reviewed and evaluated against the Information Governance Toolkit, NHSLA Risk Assessment and Care Quality Commission Outcome 21 and progress reported through the Management of Information Group.

12.2 An audit programme will be established by Professional Practice Team for care records. Results of these audits will be presented to the Effectiveness & Audit Committee.

12.3 A cororate records audit programme has been implemented as part of the Information Governance Work Plan. Progress against this Work Plan is presented to the Management of Information Group on a regular basis.

12.4 All information assets are registered with the Information Governance Team and regular reports on these assets is presented to the Management of Information Group. The reports will highlight the associated risk level to the Trust for the system and progress against action plans.

12.5 All incidents involving information management is reviewed by the Information Governance Team with reporting to the Management of Information Group and Corporate Governance Meetings.

12.6 All incidents, including information management incidents are reported on a regular basis through the Clincial, Quality, Safety and Risk Committees.

12.7 This Policy will be monitored and reviewed by the Management of Information Group in two years or earlier if legislation or national/ local guidance changes.

13 Distribution

13.1 Staff will be advised of the Policy and associate documents through the staff bulletin, information governance training and All Manager's Meetings.

Appendices

1. Information Management Framework
2. Information Management Definitions
3. Records covered by this Policy
4. National and local programme initiatives / references

Appendix 1 – Information Management Framework

Note: *This list of documents is not exhaustive but demonstrates the wide range of topics that are covered through policy, procedure or guidance on iCare for staff to follow to support good information management, both electronic and paper.*

National	FOIA Section 46 Code	Legislative
National	National Archives	Guidance
National	DH NHS Records Management	Code of Practice
TSD	Acronyms	Guidance
TSD	Action Plan	Template
TSD	Agenda Template	Template
TSD	Archive	Guidance
TSD	Batch Transfer Form	Infopath Form
TSD	Clinical Policy Template	Template
TSD	Data Quality	Guidance
TSD	Data Quality	Poster
TSD	Diaries	Guidance
TSD	Duplicate records	Guidance
TSD	Duplicate records	Poster
TSD	Email Management	Guidance
TSD	Fax	Template
TSD	File Register - electronic	Guidance
TSD	File Register - paper	Template
TSD	File Share Access	Guidance
TSD	File Share Access Form	Infopath Form
TSD	File withdrawal	Template
TSD	Flagging Violent Patients	Guidance
TSD	Incoming Post	Guidance
TSD	Information Asset	Policy
TSD	Information Asset Register	Register
TSD	Information Management Policy	Policy
TSD	Leaflet/Poster Guidance	Guidance
TSD	Managing Electronic Documents in a Shared Environment	Guidance
TSD	Minute Taking	Guidance
TSD	Minute Template	Template
TSD	Missing Records - Flow Chart	Flow Chart
TSD	NHS Number	Policy
TSD	NHS Number	Guidance
TSD	NI Numbers storage of	Guidance
TSD	Policy Management	Policy
TSD	Policy Template	Template
TSD	Post/Courier	Guidance
TSD	Principles of Good Record Keeping	Guidance
TSD	Producing Patient/Client Information	Guidance
TSD	Protective Markings (Business Classification)	Guidance

TSD	Records Management Procedure	Procedure
TSD	Report Writing - Annual Reports	Guidance
TSD	Report Writing - Business Case	Guidance
TSD	Request for Information	Procedure
TSD	Retention & Disposal Schedule	Schedule
TSD	Retention Form	Form
TSD	Safe Haven Procedures	Procedure
TSD	Scanning Documents	Guidance
TSD	Signature List	Template
TSD	Text Messaging	Protocol
TSD	Version Control	Guidance
TSD	Website Management Procedure	Procedure

Appendix 2 – Information Management Definitions

CARAT – data quality principles: **C**omplete, **A**ccurate, **R**elevant **A**ccessible, **T**imely

Care Record - anything that contains information relating to the physical or mental health or condition of an individual in community health and/or adult social care, and has been made by or on behalf of a health and/or social care professional in connection with the care and treatment of an individual.

Corporate Record – anything that contains information relating to how the organisation conducts its business on a day –to-day basis including service planning and provision, including finance, estates, human resources, IMT, purchasing / supplies.

Data – numbers, words or images that have yet to be organised or analysed to answer a specific question. It is often interchangeable with the word 'information'.

Data Quality – ensuring data is 'fit for purpose' and 'right first time', which includes the relevance, correctness, completeness and timeliness of all data held in all Trust systems

Document - smallest complete unit of recorded material which is accumulated to form a file.

Filing plans – a list of the records in an office or on a system which describes how they are organized and maintained. A good flie plan is one of essential components of a recordkeeping system and key to a successful records management program.

Folder/File– an organised unit of documents accumulated during current use and kept together because they deal with the same subject, activity or transaction.

Information – Produced through processing, manipulating and organising data to answer questions, adding to the knowledge of the receiver. It is often interchangeable with the word data.

Information Management – a collection and management of information from one or more sources and the distribution of that information to one or more audiences. Management means the organisation of and control over the planning, structure and organisation, controlling, processing, evaluating and reporting of information activities in order to meet the Trust's objectives and to enable corporate functions in the delivery of information.

Knowledge – what is known by a person(s). Involves interpreting information received, adding relevance and context to clarify the insights the information contains.

Record - is a document containing data or information of any kind by an organisation or person in the transaction of business, or conduct of affairs. They are subsequently kept as evidence of such activity.

Record Keeping - is the practice of maintaining the records of an organization from the time they are created up to their eventual disposal. This may include classifying, storing, securing, and destruction (or in some cases, archival preservation) of records.

SOAPE – methodology for recording in care records: **S**ubjective, **O**bjective, **A**ssessment, **P**lan, **E**valuate.

Appendix 3 - Records covered by this Policy

A record is information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations, or in the transaction of business. (BS ISO 15489.1)

A NHS record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees – including consultants, agency or casual staff. (DH Records Management: NHS Code of Practice)

A care record is anything that contains information relating to the physical or mental health or condition of an individual in community health and/or adult social care, and has been made by or on behalf of a health and/or social care professional in connection with the care and treatment of that individual.

A corporate record is anything that contains information relating to how the organisation conducts its business on a day-to-day basis including service planning and provision, including finance, estates, human resources, IM&T, purchasing/supplies, etc.

This includes:

- Patient health records (electronic or paper based including those concerning all specialities, and GP medical records)
- Social care records (electronic or paper based)
- Records of private patients seen on NHS premises
- A&E, birth and all other registers
- Theatre registers and minor operations (and other related) registers
- Administrative records (including personnel, estates, financial and accounting records; notes associated with complaint handling);
- X-ray and Imaging reports and images
- Photographs, slides and other images
- Microform (i.e. fiche and film)
- Audio and video tapes, cassettes, CD-ROM, DVD, etc
- E-mails,
- Correspondence i.e. letters, memos, file notes
- Minutes/notes of meetings,
- Diaries
- Digital records
- Computerised records
- Videos

A Schedule of Records is attached which indicates where care, staff, business and admin records are stored. This is a ‘live’ document and will be reviewed and amended on a regular basis.

Appendix 4 - National and local programmes, initiatives, standards and frameworks

The Public Records Act 1958
All NHS records, and those of NHS predecessor bodies, are public records under the terms of the Public Records Act 1958. The Act sets out broad responsibilities for everyone who works with such records and provides for guidance and supervision by the Keeper of Public Records.

Freedom of Information Act 2000
The organisation should carry out a records audit to determine what records it holds, the locations of the records and whether they need to be kept – this should lead to a review of the organisation's retention schedules and provide information for its publication scheme. There is a duty imposed on organisations to supply information in a timely fashion – currently within 20 working days.

The Environmental Information Regulations 2004
As with the Freedom of Information Act the organisation needs a robust records management programme. The requirements of the two pieces of legislation are similar so it is advised that organisations deal with requests in a like manner. The main difference is that requests for environmental information need not be in writing.

The Re-use of Public Sector Information Regulations 2005
Employees responsible for re-use issues should work closely with those responsible for FOI for several reasons:
An information audit is required for both pieces of legislation to determine the records held and the locations of those records
Information available for re-use and the terms and conditions of re-use can be included within the organisation's publication scheme
If a request is made for access and re-use, the processes need to be co-ordinated so that the access issue is dealt with before permission to re-use is granted

The Lord Chancellor's Code of Practice on the Management of Records, issued under section 46 of the Freedom of Information Act 2000
This code sets out the practices that organisations should follow in relation to the creation, keeping, management and destruction of their records.

Information Governance Toolkit
Requirement 104 ensures that Information Quality and Records Management arrangements are coordinated by the lead manager but incorporated within broader information governance arrangements.
Requirement 107 ensures that the Board is updated with progress against implementation plans and ensure annual review and sign off of Information Lifecycle Strategy.
400 Series requirements provide assurance against the clinical/care information.
600 Series requirements provides assurance against corporate information.

NHSLA Risk Management Standards for NHS Trusts
Most healthcare organisations are regularly assessed against these NHSLA risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks:

Care Quality Commission Standards
Outcome 21: Records
People who use services can be confident that their personal records for their care, treatment and support are properly managed, kept or disposed of in accordance with Data Protection Act, DH Records Management: Code of Practice and other professional bodies standards where applicable to the service.

NHS Care Record Service
The purpose of NHS CRS is to allow information about you to be accessed more quickly, and gradually to phase out paper and film records which can be more difficult to access.

Department of Health: Informatics Planning
The operating framework 2010/11 confirms that informatics will be included in operational plans and this document provides guidance on the informatics components of these plans. National expectations for the NHS for delivery of national and local objectives are set out, building on existing investments to strengthen local information and data management.

Department of Health Code of Practice: Records Management
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.

Ministry of Justice
The Ministry of Justice is responsible for freedom of information policy in the UK, and for development of the framework for the Act including the provision of guidance and best practice to public authorities and information applicants.

National Archives
The National Archives produces standards and guidance on all aspect of record management within the public sector.

NHS Constitution
This has many commitments on information including the right of access to your own health records which will always be used to manage your treatment in your best interest.

HM Government Information matters: building government's capability in managing knowledge and information
This strategy is designed to help government departments develop frameworks, tools and culture needed to raise our capability. By improving professionalism in this essential field, we will be ready to seize emerging opportunities, and meet the evolving challenges of managing information in an information age.

Care Quality Commission: The right information, in the right place, at the right time
A study which looked at information governance in healthcare organisations in light of increased awareness of its importance and issues beyond the headlines generated by recent breaches in data security. Information governance is about managing information for the benefits of patients and the quality of that information is just as important for their care and for the funding of organisations as they systems that manage it.

NHS Connecting for Health: Records Management Roadway
The Records Management Roadmap contains a range of practical tools and guidance designed to support organisations in the implementation of an effective records management system in line with the principles contained in the Records Management: NHS Code of Practice.

NHS The Care Record Guarantee
This guarantee is the NHS organisations' commitment that they will use records about individuals in a way that respect their rights and promotes their health and wellbeing.

The Social Care Record Guarantee
This guarantee is their commitment that they will use records about individuals in ways that respect their rights and promotes their health and wellbeing.

Professional Codes of Conduct set out standards of ethical behaviour owed by members of each profession. These include ensuring continuity of care through good record-keeping practice

Equity and Excellence: Liberating the NHS (July 2010)
This states it "will put patients at the heart of the NHS, through an information revolution"; "patients will have access to the information they want"; and "they will have increased control over their own care records".

Caldicott2 Review

Following a request from the Secretary of State for Health, Dame Fiona Caldicott carried out this independent review of information sharing to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care.