Western Health and Social Care Trust

Western Health and Social Care Trust

we are west
Caring together.
Committed to better.

1 December 2025

Records Management Policy

PPCS

ana

Western Health and Social Care Trust

Policy Title:	Records Management Policy
Reference Number:	CORP 08/003
Original Implementation Date:	March 2008
Revised:	April 2010 November 2015 June 2018 April 2021 March 2024 (No Change) December 2025 (minor changes)
Next Review Date:	October 2028
Responsible Officer:	Assistant Director of Performance, Planning and Corporate Services

Western Health and Social Care Trust

TABLE OF CONTENTS

1.0 Records Management Policy

1.1 Introduction and Scope

All Health and Social Care Northern Ireland (HSC) records are public records under the terms of the Public Records Act (Northern Ireland) 1923. The Act sets out the broad responsibilities for everyone who works with such records and therefore, the Western Health and Social Care Trust has a statutory duty to make arrangements for the safe keeping and eventual disposal of its records.

This policy gives the basis for good records management and will form the foundation of the WHSCT Records Management Strategy.

The purpose of this policy is to ensure that the WHSCT adopts best practices in the management of its records so that reliable records are created, they can be found when needed, and are destroyed or archived, when no longer required.

This policy provides for:

- The requirements that must be met for the records of the WHSCT to be considered as a proper record of the activity of the organisation, including the provision of health and social care services by or on behalf of the WHSCT.
- The requirements for systems and processes that deal with records.
- The quality and reliability, which must be maintained to provide a valuable information and knowledge resource for the organisation.
- The position of records management within the strategic and policy framework of the organisation.
- The records registration process.
- An overall statement of records management policy, which is supplemented by detailed procedures.
- The arrangements for reviewing the policy and checking the quality of implementation.

It covers records in all formats, both corporate and patient/client records, paper and electronic (including emails), created in the course of WHSCT business, including non-conventional records.

Compliance with this policy will ensure that the WHSCT can provide evidence of performance and demonstrate accountability, as well as providing information about its decisions and activities.

A list of the key legislation and other guidance documents that affect the management of Western Health and Social Care WHSCT records are included in the reference section of this policy.

Encompass

In May 2025 the WHSCT will migrate to the Encompass programme to introduce a digital integrated care record for all patients/clients. The Encompass programme will be used regionally and has been designed to reduce our reliance on paper records.

The move to encompass will help to transform the Health and Social Care services in Northern Ireland by enabling staff to work more effectively and efficiently through regional standardisation and best practice.

While the introduction of encompass will alter how patient records are created and stored, it is also important to correctly manage 'legacy records' – the term refers to all records created pre-Encompass). Some electronic records will be automatically migrated to encompass, other records may not but they will need to be maintained in an accessible format until they reach retention. Legacy paper records will also have to be maintained and managed through to retention (unless a decision is made to electronically archive the records.

Although the move to encompass signifies a substantive change to recording patient and client care, it should not affect the principles of how we manage our patient/client records as these principles apply to the management of both electronic and paper records.

1.2 Policy Statement

Information is a corporate asset and the records of the WHSCT are important sources of patient and client information in addition to administrative, financial, legal, evidential and historical information. They are vital to the organisation in its current and future work, for the purposes of accountability, and for an awareness and understanding of its history. They are the corporate memory of the organisation.

A **Record** is information that has been received, created or maintained by the WHSCT as evidence of a business activity, patient/client care, treatment given, treatment planned and can be in any format – paper, electronic, digital and/or voice. A record is anything which contains information which has been created or gathered as a result of *any* aspect of the work of employees or those providing a service– including agency or casual staff, volunteers and all contracted services.

A Document. These are recorded communication with recognisable structure regardless of medium. Not all documents are records in the archival or legal sense.

In consultation with organisations that may be concerned with the management of its records, the WHSCT will create, use, manage, destroy, dispose of or preserve its records in accordance with all statutory requirements.

Commented [HK1]: Cover introduction of Encompass

Systematic records management is fundamental to organisational efficiency. It enables the WHSCT to:

- conduct business in an orderly, efficient and accountable manner;
- deliver care and services in a consistent and equitable manner; support and document policy formation and managerial decision making;
- provide consistency, continuity and productivity in management and administration;
- facilitate the effective performance of activities throughout the Dept of Health NI , HSC and Public Safety;
- provide continuity in the provision of services, care, or treatment;
- provide continuity in the event of the WHSCT enabling business continuity arrangements;
- meet legislative and regulatory requirements including archival, audit and oversight activities;
- provide protection and support in litigation including the management of risks;
- protect the interests of the Dept of Health NI, HSC, Public Safety and the rights of employees, patients, clients, and present and future stakeholders;
- support and document current and future research, and document activities, developments and achievements, as well as historical research;
- establish and provide evidence of business, personal and cultural identity; and maintain the corporate, personal or collective memory.

The WHSCT ensures that:

- the correct information is captured, stored, retrieved and destroyed/disposed of or preserved according to need.
- it is fully utilised to meet current and future needs, and to support change
- it is protected against unauthorised access
- it is accessible to those who need to make use of it and that the appropriate technical, organisational and human resource elements exist to make this possible
- all staff are made aware of and trained in information governance and accompanying record management responsibilities within their area of work or responsibility.

1.3 Accountability for WHSCT Records

The Chief Executive, Directors, Senior Managers and designated WHSCT staff, have a duty to ensure that WHSCT complies with the requirements of legislation affecting management of the records and with supporting regulations and codes, both regional and internal.

The Director and Assistant Director of Performance and Service Improvement will have specific responsibility for Records Management within the WHSCT. The Director of Performance and Service Improvement is the Senior Information Risk Owner (SIRO) for the WHSCT and is responsible for ensuring organisational information risk is properly identified and managed and that appropriate assurance mechanisms exist. The SIRO is supported in this role by Information Asset Owners who must provide assurance to the SIRO that information risk is managed effectively for the information assets that they own

The Head of Information Governance and Records Management and the supporting Information Governance and Records Management teams will work closely with managers within each Directorate to ensure that there is consistency in the management of records and that advice and guidance on good records management practice is provided throughout the WHSCT. He/she will support the WHSCT, its directorates and employees in the development, implementation and review of the records management strategy, policies and procedures.

All members of staff are responsible for maintaining their records in accordance with the WHSCT Records Management Policy, professional guidelines and the HSC's Retention and Disposal Schedule 'Good Management Good Records' (GMGR). In particular:

1. Following the procedures endorsed by senior management.
2. Documenting their actions and decisions in records.
3. Destroying records in accordance with GMGR and accompanying procedures.

Staff who create, use, manage or dispose of records have a duty to protect them and to ensure that any information that they add to the record is necessary, accurate and complete. The confidentiality of patient, client or corporate records must always be a priority to all WHSCT staff. All staff involved in managing and/or creating records will receive the necessary training and formally acknowledge their duty of care with regard to WHSCT records.

Records and Record Keeping

Commented [HK2]: Updated to differentiate between physical records and Encompass

- Personal information collected and processed by the WHSCT, should be adequate, relevant and not excessive for the reason(s) for which it is collected or used.
- Personal information should be accurate and kept up to date.
- All physical records should be clear, relevant and concise, and indicate the identity of any persons who have made an entry in them. The use of abbreviations (where these are not standardised or agreed) and jargon should be avoided.
- Physical records containing personal information should be kept secure at all times and locked away when not in use.
- When dealing with physical records care should be taken to avoid misfiling and use proper checks to ensure that information is filed in the correct persons chart.
- Appropriate action must be taken when misfiling has been identified in a physical record.

- It is the responsibility of every individual who has access to physical records to ensure that all information contained within the physical record is pertinent to that individual patient.
- All staff who use Encompass are required to attend Encompass training. It is the responsibility of staff to ensure that they attend this training as well as line managers to ensure that all their staff have received Encompass training.
- After the Encompass system is introduced the electronic record will be the definitive record going forward. No paper will be added to legacy records, information should be directly entered onto the Encompass system in the first instance. Only when this is not possible should a physical document be created.
- Physical documentation that is created after the Encompass go live date will be required to be scanned onto the system. When scanning the physical documentation the WHSCT scanning policy should be followed as well as the Standard Operating Procedures developed by the service.
- Personal information should not be retained for longer than is necessary. All records should be disposed of in accordance with Dept of Health NI guidelines.
- A record made in any format (e.g. written, audio or visual) of meetings with patients, clients or staff must be treated as confidential and processed in accordance with the UKGDPR, Data Protection Act 2018 and other relevant policies / guidelines

1.4 Records Management Systems

Directorates and individuals need to ensure that:

The record is present;
The WHSCT has the information that is needed to form a reconstruction of care, activities or transactions that have taken place

The record can be accessed;
It is possible to locate access and evaluate the information and display it in a way consistent with the purpose for which it was created. Records will be signed, dated and appropriately filed.

The record can be interpreted;
It is possible to establish the context of the record: who created the document, during which operational or business process, and how the record is related to other records. Paper notes or records must be legible and easily understood.

The record can be trusted;
The record reliably and accurately 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;
The qualities of accessibility, interpretation and trustworthiness can be maintained for

as long as the record is needed, perhaps permanently, despite changes of formats or business processes/practices. Records will be protected during their life cycle by ensuring safe and adequate storage facilities or media.

1.5 Records Registration and Naming

Records registration / identification ensures that a link between the record and its business roots/function.

The registration of records will follow best practice in records management and allow for the users of the records to identify and track particular records and record collections. The registration system includes:

- Classifying of the records into series that have meaningful titles and a reference code, consistent with WHSCT 'naming conventions'. Identification should be consistent between corresponding paper and electronic records.

- Setting a responsibility on individuals creating records, to name and allocate those records to an appropriate work area.

- Checking that the correct records have been allocated to the sequence and that meaningful titles are used.

- Auditing lists of the references used so that the registration system makes sense and records can be found in appropriate search sequences.

Going forward all new patient/client records should be created and registered directly on the Encompass system. The Encompass system will automatically take care of the naming and indexing of records. However in scenarios where it is necessary to name an electronic record it is important to use the WHSCT 'Naming Convention', this can be located in the Records Management section of the IGHub within StaffWest.

Commented [HK3]: Updated to ensure relevant for Encompass

1.6 Closing Records

One of the main principles of data protection legislation is storage limitation. This required the WHSCT to only hold personal data for as long as is necessary. Therefore a record must be closed as soon as it is appropriate to do so and categorise it as per Good Management Good Records classifications (GMGR). The responsibility for categorising records will always fall to the record owners as the knowledge of what is contained in a particular record will be with them.

Once a record has been categorised, it will dictate how long that record needs to be retained for and what must be actioned when the record reaches its retention period.

There are three main outcomes when records reaches its retention date :

- Permanent Preservation – This may be within the organisation or with Public Records Office (NI) (PRONI)

• PRONI Appraisal – PRONI will have to be contacted to determine if they would have any interest in retaining the records. The process to follow when requesting a PRONI appraisal can be found in the Records Management section of the IGHub, it is covered in the guidance labelled 'How to Record Destruction'

• Destroy – The records can be destroyed in line with the WHSCT current disposal schedule and procedures, including the requirement to keep a record of destruction. Guidance on how to keep a record of destruction can be found in the Records Management section of the IGHub, it is covered in the guidance labelled 'How to Record Destruction'. Before destroying any records consideration will have to be given to whether or not a record is subject to any current inquiry or likely to be subject to a future inquiry.

It is the responsibility of the record owners to close and categorise their own records using the latest version of GMGR which can always be found on the Department of Health website. Once categorised a review date can be determined using the retention periods set out in GMGR. When reviewed always refer to GMGR to determine which of the above three outcomes needs to be implemented.

There is guidance available on the IGHub section of StaffWest on how the destruction of records needs to be recorded as well as what to do if records need to be appraised by PRONI. This guidance is contained within the supporting guidance folder of the records management section of the IGHub and is called 'How to Record Destruction'.

1.7 Policy Framework

The records management policy is a specific part of the WHSCT overall corporate programme and relates to other local and regional requirements, such as:-

Following Best Practice
Records should be managed in accordance with regional and WHSCT authored standards for records management such as Dept of Health NI's 'Good Management Good Records' guidelines; and supporting guidance issued by the WHSCT Information Governance and Records Management Teams, which provide a suite of documents on the IG Hub (accessible via Staff West Intranet page) in records management and associated governance.

Data Protection
Records need to be managed in accordance with procedures under the Data Protection Act 2018 and UKGDPR

Freedom of Information
Records need to be managed in accordance with the Freedom of Information Act 2000 and its related Codes of Practice.

Audit Procedures
Records have to meet WHSCT internal audit requirements and external audit as required.

Local / Internal Policies and Procedures

Commented [HK4]: Updated to refer to additional guidance available on IGHub

All Records, paper and electronic, managed according to locally agreed policies and procedures, based on legal requirements, regional guidelines and minimum standards.

"Section 75 Monitoring Guidance for Use by Public Authorities": ECNI (2007): Under the WHSCT Equality Scheme there is a statutory obligation to develop processes for monitoring the impact of policies /decisions on the 9 Section 75 Groups. Part of this monitoring requires a Public Authority to examine its current record keeping and identify gaps. The Guide provides advice and practical suggestions in this area of work.

1.8 Monitoring Compliance

The WHSCT will follow this records management policy within all relevant procedures and guidance used for operational activities. Compliance with the policy will be monitored and subject to periodic review by the WHSCT Information Governance Steering Group who will seek to:

- Identify areas of good practice which can be used throughout the WHSCT
- Highlight where non-conformance to agreed procedures is occurring; and
- If appropriate, make recommendations as to how compliance can be achieved

Inspections may be included in the programme of work undertaken by Internal Audit.

References

- Public Records Act (NI) 1923
- http://www.legislation.gov.uk/apni/1923/20/contents
- Disposal of Documents order 167, 1925
- https://www.nidirect.gov.uk/publications/disposal-documents-order-1925
- Limitation Act 1980
- Limitations (NI) Order 1989
- Freedom of Information Act 2000
- International Standard on Records Management (ISO 15489)
- Electronic Records Management: Toolkits (PRO, 2000-2002)
- Data Protection Act 2018+*: A Guide for Records Managers and Archivists* (PRO, PRONI, NAS, in association with ODPC, 2000)
- UK General Data Protection Regulation
- Data Protection Act 2018
- Records Management Standards and Guidance (PRO, from 1998)
- Northern Ireland Records Management Standards (NIRMS) (2002)
- (Public Records Office of Northern Ireland)
- The Lord Chancellor's Code of Practice on the Management of
- Records under Section 46 of the Freedom of Information
- Dept of Health NI's 'Good Management Good Records' guidelines
- WHSCT 'Data Protection an Confidentiality Policy' and associated procedures
- Computer Misuse Act 1990
- WHSCT I.C.T. policies

Western Health and Social Care Trust

Appendices

Western Health and Social Care Trust

Chart Splitting Protocol
Altnagelvin Hospital

Relevant to:

- All staff who manage the contents of health records.

Purposes:

- To ensure that health records are stored and maintained in a safe and secure manner facilitating access to all relevant records for patient care and minimising clinical risk.
- To provide guidance on standards for the internal structure and chart volume control.
- Compliance with legislation and good practice requirements

Reference Material:

- Good Management Good Records
- Legislation – including 'The Public Records Act 1923'

Triggers

When the chart thickness becomes greater than **7cm** then a new volume should be created and 'Volumes Control' guidance must be adhered to.

Volumes Control

The multiple chart volume controls will be implemented as follows.

Chart Volumes/Numbering

- When a new volume is created the ***older*** volume cover must be updated:
- A tick ☑ must be placed in the pre-printed 'Archived' box.
- Date of archive must be written into the pre-printed 'Date of Archive' box.

- The ***new*** volume cover must have the new volume number written on the chart cover in the pre-printed 'Volume Number' box and must have a tick ☑ in the preprinted 'Current' box.

The highest volume number will always be the current chart and older volumes will be kept in storage unless specifically requested.

Reserve volumes must be tidied before being filed, i.e. no loose pages and all correspondence maintained in chronological order.

New Volume Cover

When opening a new volume the new cover must be updated as follows:

- Hospital Number; must be written into the pre-printed box.
- Patient Details; must be written into the pre-printed box or a Patient Label can be used.
- The volume number must be written on the chart cover in the pre-printed 'Volume Number' box. • Place a tick ☑ in the pre-printed 'Current' box.

Chart Contents

Personal Data Sheet

The Personal Data Sheet should be updated and completed in full.

Transfer Criteria

- All clinical notes, letters, operations/anaesthetics notes, consent forms and nursing notes ***less than 3 years*** old will be transferred to the new chart
- All diagnostic reports ***less than 3 years*** old will be transferred.

Where patients have complex and lengthy hospital stays/activity it may not be* possible *to include three years activity in the new volume. In these* circumstances *the new volume must contain notes for a

minimum period of 6 months if possible.

Neonates should contain notes for a minimum period of 4 weeks.

Case Note Tracking

The IFIT tracking system must be updated to reflect the number of volumes created under the Chart Splitting Protocol. To record the details, Health Records users will advise IFIT administrators of any additional volumes created.