

Connected Care Records Management Policy

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Subject:	Connected Care Records Management PolicyTVS Records Management
Description:	The policy aims to ensure appropriate management of records in the Connected Care System

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1. Introduction

The Connected Care Shared Care Record (the 'SHCR') is the implementation of a joint processing and sharing agreement between health care providers within the Berkshire West ICP and the Frimley ICS who are members of the Regional Health and Social Care Information Sharing Agreement (the 'Regional ISA').

Scope of this policy - This policy applies to users of the SHCR.

2. Purpose

This policy sets out the principles and policy developed in conjunction with the Thames Valley and Surrey ('TVS') Shared Care Record including contributions from the Health and Care Professionals Group and the Ethics and Engagement group. As the Connected Care ShCR is one of a number of systems contributing to the TVS ShCR, it is essential for consistency between the Connected Care and TVS policies for records management.

In respect of its subject matter and in accordance with 8.1.1 of the terms of reference of the Regional ISA Information Governance Steering Group (IGSG) the policy is subject to approval by IGSG.

The policy's application to joint processing and sharing using Connected Care is subject to ratification by the Connected Care Board.

3. Principles

The SHCR consists of four significant data stores:

1. The shared care record, used to support the provision of care.
2. The anonymised dataset, used wherever possible for statistical analysis work
3. The pseudonymised dataset, for use where anonymised data can't be used and identifiable isn't necessary.
4. The identifiable dataset – where analytics is used to provide intelligence support to the provision of care.

The other datasets are all taken from a copy of the SHCR data.

Principle - The Shared Care Record is a unique information asset.

The Shared Care Record comprises of information shared from the source organisational system and presents a view of the available data that is unique to the platform and is described as '*a single consolidated and standardised view from across the different venues of care*'. This unique view will lead to specific care decisions being made based on the available data in the SHCR. Professionals will be accountable for those decisions.

In addition the SHCR holds audit trail data specific to the use of the system. The system will develop in time to have data directly inputted and be the core source for that information. It is vital that

there is a link between inputted data and the organisation/individual entering that data both from a clinical safety and potential subject access request/auditing perspective.

When the SHCR holds data directly inputted then the policy will be updated to cover how such data is ensured as:

- Authentic
- Reliable
- Integrity
- Usable

However, the current design of aspects of the SHCR means it is NOT suitable to use as evidence to answer challenges to care decisions. It is not possible to 'roll back' the SHCR to show what data was available at a point in the past for all data items, specifically those where updates overwrite the previous value.

It is therefore expected that staff using the SHCR must record the basis for their decision made on data from the SHCR in their own record systems, in much the same way they would from a phonecall or discussion with a colleague about a patient. If required, it is possible to establish with a reasonable degree of certainty if data was present or not, based on looking at the relevant source systems and logs relating to the regular data extractions.

Principle – Data retention in the SHCR will match the relevant retention in the source systems.

The NHS Records Management Code of Practice (2021) includes the following table covering 'integrated care records':

Integrated records – all organisations contribute to the same single instance of the record	Retain for period of longest specialty	Review and consider transfer to PoD	The retention time will vary depending upon which type of health and care settings have contributed to the record. Areas that use this model must have a way of identifying the longest retention period applicable to the record.
Integrated records – all organisations contribute to the same record, but keep a level of separation (refer to notes)	Retain for relevant specialty period	Review and consider transfer to PoD	This is where all organisations contribute into the same record system but have their own area to contribute to and the system still shows a contemporaneous view of the patient record.

Integrated records – all organisations keep their own records, but enable them to be viewed by other organisations	Retain for relevant specialty period	Review and consider transfer to PoD	This is the most likely model currently in use. Organisations keep their own records on their patients or service users but can grant 'view only' access to other organisations, to help them provide health and care to patients or service users.
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Whilst the SHCR is comprised of data sourced from organisational systems and does not contain any directly inputted data, then it is the last of the three categories above. The technical solution is essentially facilitating a view of records from other organisations, whilst those organisations keep their own records.

On that basis data in the SHCR will be retained for the relevant speciality period. In addition the audit trail data must be retained for the same period as the record.

The systems that feed data to the SHCR are subject to varying minimum periods of retention which range from 8 years after discharge (Acute episode) to 30 years (Cancer cases) to the lifetime of the patient & 10 years (GP data).

When the SHCR has data recorded directly into it this principle will be reviewed at that point the SHCR will be the authoritative source of that data and will need an appropriate retention period defined.

Principle – Amendments or deletions due to accuracy concerns will be carried through to the SHCR.

Where data that is provided to the SHCR is updated, amended or deleted due to issues over the quality and accuracy of the data in a source system, this will be carried through to the SHCR and each of the data stores.

Principle – Any partner organisation that decides to withdraw their participation in the SHCR will no longer feed data to the system and the data shared up to that time will be identified and deleted or hidden.

Whilst it is unlikely a partner will withdraw from the programme, there needs to be agreement on how this will be managed. Each partner retains control over their individual participation and can withdraw (items such as notice periods would be covered in relevant data sharing agreements).

If a partner withdraws, their data will no longer be updated, and this introduces a growing level of clinical risk for any use of that data. Additionally, if the data was kept, its usefulness and therefore necessity to use and store in the ShCR also decreases. Therefore, if a partner withdraws, all data they have provided will be removed from all the data stores. Any withdrawal needs to be communicated to the other organisations in the SHCR partnership.

Principle - The anonymised dataset is not personal data and not subject to personal data legislation

The anonymised dataset will be built from the SHCR as one of the datasets to support analytic activities, however as any personal identifiable data will be removed in this dataset, the legal requirement from GDPR to keep personal data for the minimum period does not apply.

On the basis that the anonymised dataset is not subject to the same legal restrictions, the retention of the dataset will be periodically reviewed (time period to be determined).

Principle - The pseudonymised dataset is personal data but may not be subject to the same retention requirements as the integrated care record.

The GDPR and the Data Protection Act 2018 allow for data that is processed for scientific research or statistical purposes to be kept for longer periods provided appropriate safeguards, such as pseudonymisation have been put in place. There is a specific Data Protection Impact Assessment for the development and use of the Intelligence platform (DPIA0002) that assesses the legal compliance of the pseudonymised dataset. It is expected most outputs of analysis from the pseudonymised dataset will be aggregated statistics.

It is proposed that the retention of data in the pseudonymised dataset is reviewed on an annual basis by the IG Steering group, based on assessment of the uses of the dataset.

Principle - The identifiable dataset is personal data and is subject to the same retention as the shared care record.

The identifiable dataset is provided to link the benefits of analytical activities to the provision of care and is essentially for use within the health & care definition of 'direct care', hence should be subject to the same period of retention

Principle - Access to records of patients who die will be locked to a specific usergroup

Taking account of retention periods as detailed above, the need to access records of deceased individuals swiftly reduces soon after they have died. Deceased records will be limited to a small defined user group when the system has been notified of their death. Clinical and service staff will be asked to identify why they need access to the usergroup and a process for allocation established.

Principle - Data on individuals who move out of the region covered by the SHCR will be retained in line with overall retention and not deleted after they have moved.

Where an individual's general practice details are updated and are no longer within the region, the data on these individuals will be retained on the basis that their records may be needed for urgent care within the region and a number will move back in the future. If records have been deleted, then it may not be possible to reconstitute all previous data from sources.

Principle – record storage

All data is stored in the Graphnet CareCentric product in a Microsoft Azure data centre. Storage requirements are covered by the relevant Data Protection Impact Assessments and Graphnet security documentation.

4. Monitoring

Monitoring Compliance with Policy

Compliance will be monitored by periodic 'deep dive' audit of the principles defined within the policy to be undertaken by appropriate subject matter experts.

Glossary: Document Control

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