Deputy Chief Executive's Office &
Directorate of Operations
Clinical Support Services
Health Records Library

HEALTH RECORDS MANAGEMENT POLICY & STRATEGY

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Contents

1.0 Introduction Purpose & Scope

1.1 All NHS Health Records are public records under the terms of the Public Records Act 1958.

1.2 Under the Act, and in accordance with Controls Assurance, the Trust has a statutory duty to make arrangements for the retention, preservation and/or destruction of such records. These arrangements should to take into account the Trust's Risk Management Strategy.

1.3 A Health Record is defined as anything, which contains information, which has been created or gathered as a result of any aspect of the work of NHS Health Professionals regarding an individual patient.

1.4 Health Records are valuable owing to the information they contain. They form a legal document.

1.5 Information should always be correctly recorded, should be regularly updated as necessary and is easily accessible when requested.

1.6 Standard Health Records support:

- Patient care and continuity of care
- Operational management which underpins delivery of care
- Evidence based practice
- Sound administrative and managerial decision making including external audit
- Compliance with legislation
- Clinical Governance & Clinical Audit
- Professional development of clinical staff
- Clinical and Administration policy and processes
- Reduction in risk
- Training processes
- Cost effective use of resources

1.7 NHS Trusts have a statutory duty to make arrangements for the safekeeping and eventual disposal of their Health Records.

1.8 In accordance with the Records Management – NHS code of Practice and Information Governance Standards the Trust is required to have a Health Records Strategy in place.

1.9 This document covers the Health Record types as given in Appendix 3 of the Information Governance Alliance, Records Management, Code of Practice for Health and Social Care 2016

2.0 Area

This policy applies to all staff working within Northern Lincolnshire and Goole NHS Foundation Trust.

3.0 Policy Statement

3.1 Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) recognises the importance of effective Health Records Management. Health Records should be created in accordance with this strategy and policy, they should be readily accessible and available for use, and eventually archived in accordance with national guidelines.

3.1.1 All Trust staff should ensure:-

- Both the quality and quantity of information that it generated is controlled and maintained
- That information is maintained in an effective manner
- Health Records are delivered across all locations so as to be available to the right people at the right time
- Information is disposed of efficiently when it is no longer required, in accordance with national guidelines
- Health Records used in the community are transported safely and returned at the end of the working day, where not possible records should be stored in a safe place overnight

3.2 Health Records have a significant role within patient care. The content and condition of Health Records are issues of vital significance to Clinical Governance and the continuing care of the patient.

3.3 Health Records that are used well and carefully contribute to:

- Improved patient care
- A reduction in clinical risk
- A reduction in patient complaints
- Achieving NHS Litigation Authority (NHSLA) Risk Management Standards 1 and contributing towards NHSLA Risk Management Standards Level 2
- Meeting data quality standards
- Clear and concise understanding for all staff using the Health Records

4.0 Duties and Responsibilities

4.1 **Trust Board** – Under the terms of the Public Records Act (1958) and the principles of the Data Protection Act 1998 the Chief Executive and relevant Directors of the Trust are personally accountable for the quality of records management, which includes Health Records.

4.2 **The Caldicott Guardian** is responsible for advising in respect of any Health Records containing person identifiable information. The Guardian is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

4.3 **Directors/Operational Group Managers/Departmental Heads** will have responsibility for informing and ensuring staff compliance with this policy.

4.4 **The Trust Clinical Documentation Manager** will on behalf of the Head of Governance have the responsibility to lead in developing policies and protocols related to Clinical Documentation, ensuring compliance with corporate quality standards, as part of the Trusts wider documentation control arrangements and their implementation.

4.5 **Health Records Committee (HRC)** is accountable to the Trust Governance Board and acts as an executive group with responsibility for influencing and implementing Health Records policies and procedures within the Trust. The committee has the responsibility of reviewing audits pertaining to Health Records management and for monitoring the implementation of action plans arising from the audits.

4.6 **The Health Records Site Managers** are responsible through the HRC for the overall development and maintenance of Health Records Management Practices throughout the Trust, in particular for devising guidance for good records management practice and promoting compliance with the 'Health Records Management Policy & Strategy' in such a way as to ensure that records are secure, accessible, well maintained and disposed of appropriately or permanently preserved. The Health Records Site Managers will communicate any records management issues to the HRC.

4.7 The responsibility for the care of the Health Records lies with all Trust personnel who handle them.

5.0 Health Record Keeping Standards & Audit Requirements

5.1 Record keeping is a tool of professional practice and one which should assist the care process.

5.2 Health Records should be:

- Factual, consistent and accurate
- Written up as soon as possible after an event has occurred, providing current information
- Written clearly and in such a way that the text cannot be erased
- Any alterations or additions should be dated, timed and signed in such a way that the original entry can still be read clearly

- All entries should be accurately dated, timed and signed with the signature printed alongside the entry, or as directed on collaborative documentation
- No abbreviations or jargon should be used (unless officially accepted by the HRC)
- No meaningless phrases, speculation or offensive subjective statements should be documented
- Readable when photocopied
- Written in black pen/biro/ink (Other colour biros are permissible if they are indelible and readable on photocopying)
- The use of correction fluid is forbidden in Health Records

5.3 The Health Record should be bound and documents stored in such a way that the loss of documentation is minimal

5.4 Volumising stickers must be clearly marked/placed in the centre of the Health Records front cover and should be clearly visible.

5.5 Year stickers must be clearly placed on the top left hand corner at the front of the Health Records.

5.6 Only labels/stickers approved by the Trust HRC can be affixed to the front of the Health Record.

5.7 Staples, pins or sticky tape must never be used to attach notes, photographs or loose leaf items to the Health Record folder.

5.8 The plastic pocket on the back of the inside cover must be used for patient identification labels only.

5.9 The Health Record specialty dividers will be based on colour coding approved by the HRC.

5.10 All Trust Health Record documentation will be printed in black text on white paper unless justification has been provided and subsequently approved by the HRC.

5.11 Only colours approved by the HRC will be used as a coloured background for any clinical documentation.

5.12 Signed approval is required from the Chair of the HRC, before any Health Record/clinical documentation colour standard will be implemented.

5.13 All clinical documentation colours will be maintained as part of the Trust Clinical Documentation Control Register.

5.14 Divider filing instructions are in place as agreed by the HRC.

5.15 All documents must be filed behind the correct divider.

5.16 Paediatrics should be the only speciality to file ‘in date order’ and not by ‘Consultant and date order’.

5.17 Health Records audits will be carried out monthly. KPI reports will be produced in conjunction with the Health Records KPI Audit Guide based on the minimum content set out in the KPI document.

5.18 The findings from the audits will be presented to HRC. The development and review of action plans will be the responsibility of HRC. Progress against action plans will be formally monitored via the HRC Meetings Structure.

5.19 Monthly audits will be carried out on the availability/non-availability of Health Records for upcoming attendances. The findings will be presented to the HRC.

5.20 Where a patient or visitor is identified as being violent or aggressive and a warning letter has been issued, the Local Security Management Specialist (LSMS) will review the incident details and determine whether a "violent patient" marker should be applied (in accordance with guidance issued by NHS Protect) to the Health Records, to highlight any future risk to staff should the visitor or patient represent themselves for treatment. It should be noted that the marker must be reviewed after 12 months and if there have been no further incidents, or the risk is considered to have decreased, then the marker should be removed. The LSMS will maintain records of violent patient markers applications.

5.21 If, however, the patient does not comply with the formal warning, then this will result, at the request of the Director/Manager (or nominated deputies), in exclusion/withdrawal of treatment from the Trust. This will be confirmed with a letter from the Chief Executive sent to the person informing them of their exclusion and a letter sent to their GP.

5.22 The LSMS should email nlg-tr.CorporateHealthRecordsEnquiries@nhs.net and all system administrators copies of the patient warning letters and all patient admin systems updates with this information both physical and electronic. Formal warning letters/Exclusion Order will be filed behind the Health Record Alert sheet inside the patient Health Records, a "violent patient" marker ('!') sticker will be attached to the Patient Clinical Alert sheet and a marker will be notated on CaMIS PAS in the qualifier field on PMI by Health Records staff. Once a patient attends clinic with a "violent patient" marker ('!') sticker attached to their Health Records, it is the responsibility of the Receptionist or the Nursing Team preparing the records to ensure the relevant personnel are made aware of the formal letter issued to the patient. If deemed necessary the clinical team can contact the LSMS or site Security team for further advice prior to the patient being seen.

5.23 A patient can request that their gender be changed in a record by statutory declaration, but this does not give them the same rights as those that can be made by the Gender Recognition Act 2004(67). The formal legal process (as defined in the Gender Recognition Panel Act 2004(67)) is that a Gender Reassignment Certificate is issued by a Gender Reassignment Panel. At this time a new NHS number can be issued and a new record can be created, if it is the wish of the patient. It is important to discuss with the patient what records are moved into the new record and to discuss how to link any records held in the other institutions with the new record.

6.0 Record Registration & Creation

6.1 A new Health Record should be created for all new patients attending the Trust for the first time.

6.2 All new Health Records must be allocated specialty divider(s) relevant to the speciality the patient is attending.

6.3 All Health Records must include a Patient Clinical Alert Sheet and Health Record Alert Sheet.

6.4 Any paper records stored outside the Main Health Record must contain the patients' unique patient identifier. It is the responsibility of all NLaG staff to ensure patient details are notes on every piece of paper filed in the main Health Record, (PMI) and NHS Number. A&E (CAS) cards for all patient admissions will be copied and filed in the main Health Record. Patients attending A&E who have not previously attended the Trust but are not admitted, will not be issued a PMI number or any physical Health Records created, but will be given a unique A&E identifier and the NHS Number must be recorded on the A&E record (Manual & Electronic).

6.5 All new Health Records should comply with the current NHSLA standards and Information Governance standards.

6.6 The Health Record CRT label must contain the following only, PMI number, barcode, surname, forename D.O.B and gender.

6.7 Correct patient identity must be maintained throughout the Health Record to prevent inappropriate record entries, incorrect filing and patient misidentification incidents.

6.8 Where a patient has more than one patient identifier, every effort will be made to merge the records to show the full patient history.

6.9 When Health Records become unfit for purpose, the folder should be repaired or replaced.

6.10 Health Records along with Maternity Records must be available at the first ante-natal outpatient consultation.

6.11 All active Health Records will comply with this policy.

7.0 Records Confidentiality, Security & Storage

7.1 The Health Record should not be removed from Trust premises without prior approval from the Health Records Site Managers or nominated deputy (please refer to the Transportation Conveyance of Health Records Process for further details).

7.2 When Health Records are not required for operational purposes, they should be tracked and stored in the appropriate Health Records Library.

7.3 Health Records should be filed in a way that facilitates their location and retrieval i.e. terminal digit or sequential order.

7.4 When moving Health Records between Trust hospital sites and departments, the intended destination of the Health Record must be tracked with the Health Records Library (In accordance with the CRT Tracing Operational Guidelines).

7.5 All Health Records must be stored in a secure area for which restricted access applies.

7.6 Storage and location of Health Records will be based on a number of factors such as:

- Health & Safety Regulations (fire risk, ergonomics)
- Risk assessment
- User requirements
- Record types
- Size & Quantity
- Usage
- Retention & Destruction
- Legislation

Each of the Health Records Libraries will be assessed periodically by a trained Trust Health & Safety Advisor to ensure compliance with the above.

7.7 All Health Records within the Trust will be stored, distributed and disposed of in accordance with relevant legislation (Data Protection Act 1998, Human Rights Act 1998), guidance (Caldicott 1997, Information Security Management ISO/IEC 27002: 2005) local policies (Trust Confidentiality Policy) and take account of best practice.

7.8 Periodically records management will be reviewed by internal (Clinical Audit & Controls Assurance) and external bodies (NHSLA) to ensure compliance with security and storage standards.

7.9 The Trust will have a rolling programme to underpin storage management of all Health Records.

7.10 The Trust will use off-site commercial contractors to supplement storage accommodation for Health Records.

7.11 Health Records will be requested from off-site storage as necessary and returned accordingly.

7.12 The Corporate Library Services Support Team should be notified of any Health Records required for Permanent Preservation or Life Preservation. Such records will be identified with an appropriate Permanent Preservation or Life Preservation Sticker and indicated on the Patient Administration System CAMIS (PAS) as *PERMP* or *LIFEP*.

7.13 Where a Health Record cannot be found, it will be reported on an incident report form and the Directorate/Department Manager informed.

7.14 Where a Health Record is logged as missing, a temporary set will be made up as far as is possible to support patient care. If a set of records is not available for a clinic attendance which are necessary for a patient attendance, but the whereabouts of the record is known, a temporary set should be created, once the original record is located/or arrives post clinic appointment/admission the temporary set must be merged with the main Health Record.

8.0 Tracing & Tracking of Health Records

8.1 All Health Record movements should be recorded on the CRT tracking module on the Patient Administration System.

8.2 Health Records being sent from department to department should never be sent via the internal mail system, they should always be delivered by hand.

8.3 Where Health Records are requested by another organisation, a photocopy of the records must be sent and the originals retained within the Health Records library (see Transportation Conveyance of Health Records Process for further instructions). Where photocopies of the original records are posted, the records will be sent by registered post and a proof of delivery slip must be retained by the Medico Legal Department.

8.3.1 Records sent to other organisations will have a return date.

8.4 Transportation of records to and from off-site storage facilities will be covered under the contractual arrangements.

8.5 Transportation of records from one Trust site to another Trust site will be via the internal contracted courier service.

8.6 In exceptional circumstances records can be transferred via taxi or a staff member or shuttle bus with the agreement of the Health Records Site Managers (or nominated deputy) and must meet the following criteria:

- The records must be secure in a sealed envelope/box
- They should be transported securely either in the locked boot of a car/van or in panniers on a motorbike, best practice being in a locked case in a locked boot

8.7 Records should not be in a car when it is unattended and must never be left in a car overnight. In particular extra care must be taken when transporting patient identifiable information and confidential Trust information, for example staff diaries containing patient names, addresses and phone numbers.

8.8 At least 100% of all Trust records must be traced and available at their destination should they be required for a clinic or admission. However it is recognised that owing to many different circumstances this target will not always be met.

8.9 Further guidance can be obtained from the Trust's 'Creating, Tracing/Tracking Health Records Electronically (CRT) Procedures'.

8.10 For guidance on availability and retrieving of Health Records, please refer to the Health Records Unavailability/Availability Procedure.

9.0 Retention & Destruction Management

9.1 The HRC will be advised each year of the annual destruction programme by the Health Records Site Managers.

9.2 Contractors used to undertake the destruction process will be certified to do this work, and a certificate of compliance will be issued and held within Northern Lincolnshire & Goole NHS Foundation Trust each time a contractor is engaged. Destruction management of clinical records will ensure that confidentiality is safeguarded at every stage.

9.3 Destruction will ensure complete illegibility and will either be carried out shredding, pulping, incineration or in the case of electronically held data, by purging the magnetic media.

9.4 The Trust will not retain paper Health Records indefinitely for the purpose of future litigation.

9.5 Destruction will be normally actioned after the minimum retention period specified, unless the Trust identifies the record for retention for an extended period. Any Health Record preservation will be proposed to the Health Records Site Managers (or nominated deputy) and agreement sought from the HRC.

9.6 Where clinical records are identified as having been used in cases of litigation, reference must be made to the Legal Services Department before destruction.

9.7 In the event of a clinician involved in litigation claiming that the prior disposal of relevant clinical record has prejudiced the outcome, this fact will be considered along with all other influencing factors.

9.8 The Trust will calculate the recommended minimum retention periods from the end of the calendar year, following the last entry made in the Health Records/PAS.

9.9 Where clinical records have been destroyed the PAS will be annotated appropriately. All other Clinical System/Information System Managers will be informed of the patient records that have been destroyed so that their systems can be updated appropriately (if appropriate).

9.10 Further guidance can be obtained from the Trust Destruction & Retention Policy.

9.11 Off site private patient attendances will not be recorded on the Trust's PAS system and the clinician should not utilise the Trust's Health Records, the clinician must keep their own copy of the episode documentation.

9.12 On site private patients attendance may be recorded on the PAS system, however the clinician should not utilise the Trust's Health Records, the clinician must keep their own copy of the episode documentation.

10.0 Electronic Records

10.1 The recommended minimum retention periods will be applied to both paper and electronic Health Records.

10.2 The Trust will seek to ensure that electronic data is managed to prevent any corruption or deterioration (see Information Security Management ISO/IEC 27002: 2005 and the Trust Information Security Policy for further guidance).

10.3 The migration from paper to electronic integrated patient records will be co-ordinated and governed at all times by the need to maintain the contemporaneous record.

10.4 Until Health Records are entirely produced in an electronic format, records should be printed off and stored as a paper record within the single Health Record to show continuity of care or a link should be recorded in the paper records to indicate that an electronic file exists.

11.0 Monitoring Compliance and Effectiveness

11.1 The HRC will monitor the compliance and effectiveness of this document and any subsequent revisions will be discusses at the monthly/bi-monthly meetings through and the collection of evidence that all correct actions have been carried out.

11.2 Regular and systematic audits of Health Records and Records Management are necessary to monitor compliance with the Health Records Management Strategy. The Health Records Site Managers/nominated deputy are responsible for auditing services areas annually and reporting results and action plans through to the HRC. Audits will be completed using the Key Performance Indicators across an appropriate sample size. (Please see Appendix C)

11.3 Adverse incident reporting of “lost” records will be analysed and reported to the HRC to identify areas of potential risk and any trends in incidents. This will facilitate action planning and implementation to meet identified gaps in the process.

11.4 Compliance with the strategy, and related policies and procedures will be measured against the NHSLA standards for record keeping and will be monitored by the HRC. Key performance indicators used for this will include:

- Levels of complaints with tracking requirements
- Availability of Health Records for clinics i.e. how many temporary/duplicate Health Records were only available
- Prepping Standards

12.0 Training

12.1 Trust staff will receive training in Health Records Management where deemed appropriate. Training will depend on staff responsibilities and their involvement with Health Records via personal training plans. Training will be agreed between the Health Records Site Managers, staff members and Departmental Leads/Supervisors.

12.2 New staff will receive familiarisation training at induction.

12.3 Training will be provided by trained Health Records Trainers only.

12.4 All employees who use or create a Health Record will sign a training plan to state they have received and understood their Health Record training. Health Records Trainers will countersign the training plan to document that training has been provided and understood.

13.0 Access to Records

13.1 Under the Data Protection Act 1998, the right of 'subject access' allows an individual to gain access to personal data held about them. This will involve supplying an individual with access to a copy of their record when asked to do so. The 'Access to Health Records Act 1990' applies to requests for access or a copy of records of deceased patients by their personal representatives (relation, legal guardian).

13.2 Formal requests for access should be made in writing to the Medico Legal Department.

13.3 Access to a personal record will be facilitated within 40 days of receipt of a bona fide request.

13.4 Personal data contained within a record may be shared with other people/organisations, but only with written permission from the patient/personal representative and in accordance with the Data Protection Act 1998.

13.5 The patient restricted access section of the Health Record (which contains third party information) must be removed or information redacted.

13.6 All documentation relating to safeguarding should be filed behind the safeguarding, blue tabbed divider. The information should be filed in date order, most recent on the top. If the child has changed address as they have been placed with foster carers, this information should be filed in front of the divider and should be updated accordingly with accurate demographic information.

13.7 If the parents of a safeguarding child request access to the child's Health Records, this request should be discussed with the Medico Legal Department who in turn will discuss the request with the Head of Safeguarding.

13.8 Further guidance can be obtained from the Subject Access to Health Records Policy.

14.0 Accountability

14.1 All Trust employees, within their professional scope, have a responsibility for the maintenance and management of the Health Record.

14.2 All Managers within scope of responsibility are personally accountable for the quality of Health Record management within the Trust.

14.3 All Line Managers/Supervisors must ensure that their staff (where appropriate) are adequately trained in 'Health Records Management' procedures.

14.4 Ownership and copyright of these records is with the Trust and not with any individual employee.

14.5 The responsibility for the care of the Health Record lies with all Trust personnel who handle them.

15.0 Review

15.1 This Strategy & Policy document will be reviewed every 3 years or, on an 'as and when' basis as deemed appropriate.

15.2 Approval for additions/amendments to this policy will be agreed and approved by the HRC and ratified by Clinical Support Services Governance.

16.0 Associated Documents

16.1 The Protection & Use of Patient Information & Data Protection Policy.

16.2 Information Security Policy.

16.3 Destruction & Retention Policy.

16.4 Controls Assurance Standards.

16.5 Creating, Tracing/Tracking Health Records Electronically (CRT) Procedure.

16.6 Single Health Records Filing Guidelines.

16.7 Health Records Unavailability/Availability Procedure.

16.8 Destruction and Retention Policy.

16.9 Health Records Volumising Guidelines.

16.10 Health Records Prepping Guidelines.

16.11 Transportation of Health Records Policy.

16.12 Subject Access to Health Records Policy.

17.0 References

17.1 Data Protection Act 1998.

17.2 Caldicott Guidelines 1997.

17.3 Records Management: Code of Practice for Health and Social Care 2016.

17.4 Information Governance Toolkit Standards.

17.5 Allied Health Professionals Record Keeping Standards.

17.6 **AOMRC** – Medical Records Keeping Standard.

18.0 Definitions

18.1 **CRT** – Clinical Records Tracking.

18.2 **CAS** – Casualty Administration System.

18.3 **KPI** – Key Performance Indicator.

18.4 **EPR** – Electronic Patient Record.

18.5 **PAS** – Patient Administration System.

18.6 **HRC** – Health Records Committee.

18.7 **PMI** – Patient Master Index (Number allocated by PAS system, unique to patient).

18.8 **NHSLA** – NHS Litigation Authority.

18.9 **CQC** – Care Quality Commission.

18.10 **CMIS** – Circonia Management Information System (Maternity EPR).

18.11 **SystmOne** – Electronic system record.

18.12 **AOMRC** – Academy of Medical Royal Colleges.

18.13 **CSS** – Clinical Support Services.

18.14 **NLAG** – Northern Lincolnshire and Goole Hospitals NHS Trust.

18.15 **SAT** – Speciality Administration Team.

18.16 **TCI** – To come in.

18.17 **CaMIS** – Clinical and Medical Information System.

18.18 **ETT** – Extended Therapy Team.

18.19 **SLT** – Speech and Language Therapy.

18.20 **NT** – Nutrition and Dietetics.

18.21 **ALD** – Adult Learning Disability.

19.0 Consultation

19.1 Clinical Support Services Governance.

19.2 Health Records Committee.

20.0 Dissemination

20.1 Via the intranet.

20.2 Clinical Support Services Governance.

20.3 Health Records Committee.

21.0 Equality Act (2010)

21.1 In accordance with the Equality Act (2010), the Trust will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Trust will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

21.2 The Trust will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Trust's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).

The electronic master copy of this document is held by Document Control, Directorate of Performance Assurance, NL&G NHS Foundation Trust.

Appendix A

Community Health Record Management

- Community records consist primarily of hand held records in plastic wallets or folders.
- Labels used in Community records can be located in either a plastic wallet or a bound file.
- Some Community records can be on coloured paper.
- Community notes are filed in date order of consultation for example the beginning of the record will contain the first consultation.
- Community patient records must be completed as per the professional record keeping policies (reference section 16)
- For Community all patient clinical alert sheet will be within SystmOne.
- For community only the NHS number is used.
- Community records can be transported between locations as necessary.
- At the end of every Community visit, the patient records will be returned back to their base.
- Community records will be located in the relevant department and will be stored in year order, and alphabetical order.
- Community records will be signed out in the local departments so they can be retrieved and tracked.
- Within Community services the process of requesting notes from off-site storage will be undertaken by the relevant manager for the specific department requesting.
- The movement of Community records will not be logged on a CRT. The movement is logged on tracer cards that are locked in secure cabinets.
- The transportation of Community records on visits will be the responsibility of the individual to ensure that the records are kept safely and are confidentially secured at all times.
- Private patient information within the Community records will be stored with all other patient Community records.

ETT NL
(S1 = SystmOne)

COMMUNITY SERVICES STORAGE AND DESTRUCTION SCHEDULE

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Physiotherapy	Adult & Paeds	Paper Contacts on S1	SGH Physio Dept	SGH Physio Dept	Adult 8 Years Children 25 Years
Community Stroke	Adult	Electronic S1 & Paper	SGH Stroke Office	SGH Stroke Office	8 Years
SLT	Adult	Electronic S1 since 2012	Electronic	Restore	8 Years
N&D	Adult & Paeds	Electronic S1 Since 2014	Electronic	SGH Dietetic Cupboard	8 Years 25 Years
Wheelchairs	Adult & Paeds	Electronic S1 & Paper	Wheelchair Office Monarch House	Monarch House & Restore	8 Years 25 Years
Rehabilitation Medicine	Adult	Electronic S1 & Paper	Barnard Court and Restore	Barnard Court and Restore	8 Years
Weight Management (This service ceased in 2014)	Adult	Electronic S1 and Paper	Monarch House	Monarch House and Restore	8 Years
MSK	Adult and Paeds	Primarily Paper, with some records on S1	Moving to paper light in the near future	Stored in Dept for 2 years then sent to Restore	Adult 8 Years Children 25 Years
Pain Team	Adult and Paeds	Electronic S1	Electronic S1 only	N/A	Adult 8 years Children 25 Years

Community Dental and Psychology

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Community Dental	Adult & Paeds	Electronic SOEL & Paper	In Clinics and Restore	In Clinics and Restore	Adults 11 years Children up to 25th Birthday or 26th if person 17 at time of treatment 8 years after patients death
Psychology	Adults	Electronic S1 & Paper	In Psychology dept & Restore	In Psychology dept & Restore	20 years after treatment or 8 years after patients death

ETT North East Lincs

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Physiotherapy, Hand Therapy & Rheumatology	Adult & Paeds	Electronic S1	DPOW Physiotherapy Department- 1 year. Others stored at Restore. Laptops stored in locked filing cabinet. Aim is for future paperwork to be scanned onto S1 rather than stores as paper files.	DPOW Physiotherapy- locked room for 1 year. Restore storage.	Adult 8 years Children files stored and then destroyed once 25.
Community Stroke	Adult & Paeds	Electronic S1 for case notes.	DPOW Stroke Unit Paper referral and assessments kept in locked filing cabinet	Old paper files are stored at Restore. No new paper files are archived. scanned then destroyed via confidential waste system.	8 Years
SLT	Adult	Electronic S1 and Paper.	Electronic Paper documents scanned onto S1 once patient is discharged.	Old paper files are stored at Restore. No new paper files are archived. Destroyed via confidential waste system.	8 Years
N&D	Adult & Paeds	Electronic S1 for acute and paediatric teams. Adult community continue to use a mixture of S1 and paper records.	Paper records stored in locked filing cabinets. On discharge, patient information scanned onto S1 and then destroyed via confidential waste system.	Old paper files are stored at Restore. No new paper files are archived.	8 Years Children's files stored until they reach 25.
Wheelchairs	Adult & Paeds	Electronic S1. Any paper based assessments, reports etc. are scanned onto S1.	Wheelchair Office Assisted Living Centre	Old paper files are stored at Restore. No new paper files are archived. Currently collecting rest of paper files and boxing up for storage at Restore. Documents then destroyed via confidential waste system.	10 Years Children's files stored until they reach 25.
ALD	Adult	Electronic S1 and on ''T'' drive (Care Plus Group) password protected word documents.	Electronic	Old paper files are stored at Restore. No new paper files are archived.	8 Years

Podiatry	Adult and Paeds	Electronic S1	Electronic	All previous paper records stored via Restore.	8 Years Adults. Children's filed stored and then destroyed once 25.
Family Nurse Partnership	Both	Electronic S1	Small amount of Paper records	N/A as on graduation go to Health Visiting.	N/A

Core Therapy North Lincs

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Localities NL	Adult	Paper Contacts on S1	Duchess House The Angel Brigg	Previously used Restore	Adult 8 years
Intermediate Care NL Winterton	Adult	Eletronic S1 and Paper	Sir John Mason House	Sir John Mason House	Adult 8 years
MacMillan Therapy Project	Adult	Electronic S1 and Paper	Duchess House	Duchess House	Adult 8 years

NL Children's Therapy Team

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Physiotherapy	Paeds	Electronic S1 only	N/A	N/A	N/A
Occupational Therapy	Paeds	Electronic S1 & Paper	Monarch House	Restore	25 Years
SaLT	Paeds	Electronic S1 & Paper	Monarch House	Restore (Twice Yearly)	25 Years

Acute and ST NL

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Physiotherapy ACUTE SGH	Adult & Paeds	Paper Records and contacts on S1	SGH Therapy Dept	SGH Physio Dept	Adult 8 Years Children 25 Years
Occupational Therapy ACUTE SGH	Adult	Paper Records and contacts on S1	SGH Therapy Dept	SGH Stroke Office	8 Years

Physiotherapy ACUTE GDH	Adult	Paper Records and contacts on S1	Ward 3 Therapy Room Ward 5 Therapy Room	Physio Department Goole	8 Years
Occupational Therapy ACUTE GDH	Adult	Paper Records and contacts on S1	Ward 3 Therapy Room Ward 5 Therapy Room	Physio Department Goole	8 Years

Equipment Services

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Equipment Services	Adult and Paeds	Electronic System BEST	Electronic	N/A	Adult 11 Years Children 25 Years

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Podiatry	Adult and Paeds	Paper Light all ptrmationce on S1	Electronic S1 only	N/A	Adult 8 Years Children 25 Years
Dietetics	Adult and Paeds	Paper Light all ptrmationce on S1	Previous paper records at Restore	Restore – paper records prior to 2013/2014	Adult 8 Years Children 25 Years
Hand Therapy	Adult and Paeds	Electronic S1	I Drive	N/A	Adult 8 Years Children 25 Years
Wheelchairs	Adult and Paeds	Electronic S1 & old paper records	Electronic S1 only	Old paper files stored in the department	Adult 11 Years Children 25 Years
SLT	Adult and Paeds	Electronic S1	Electronic S1 only	Old paper files stored at Restore	Adult 8 Years Children 25 Years
Community Stroke	Adult	Electronic S1 primarily, some paper records	Electronic S1 only, paper files stored in Physio	Paper files moved to Restore after 2 years	Adult 8 Years
ALD	Adult and Paeds	Electronic S1	Electronic S1 only	N/A	Adult 8 years Children 25 Years

Speech and Language Service for Adults

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Speech and Language Service for Adults with Learning Difficulties	Adults	Electronic S1 & protected word files	Electronic S1 and T Drive (Care Plus Group)	All related paper records (e.g. assessment forms are scanned into word file and the original shredded)	Adult 8 years

Child Health Records

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Child Health Record	Paeds	Electronic S1	Electronic S1	N/A	Electronic record kept until the child reaches 19 years of age or moves out of the area
	Paeds	Paper	For any school aged child moving in to North Lincolnshire the paper record would be forwarded to Restore, for any child moving out of North Lincolnshire the paper record is retrieved from Restore and forwarded to the appropriate Child Health Dept	All school age children records are stored at Restore. All paper records for Children born 1992-2009 stored at Restore, prior to 1992 the records were scanned by Restore and stored on discs – currently stored at SGCT	Children 25 years

Health Visiting

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
Health Visiting	Adult and Paeds	Electronic S1, any paper records are scanned in	Paper assessments used in clients homes are scanned in to S1	Filing cabinets for tracer cards for every child/family – limited demographic ptrmation. Process now is for all historical information to be scanned into the system. Staff do have diaries with patient information e.g. pt times and names etc. S1 ledgers are used to book all appts via client records & when mobile technology available staff to move to electronic ledgers.	Adult 8 years Children 25 years

Rehab Medicine

Service	Adult/Paeds	Records Electronic/Paper	Storage	Archive	Destruction
General Community, Health and Neck, General Wardsm Dysfluency, Voice, Parkinsons Disease	Adult	Electronic S1 for all note and report writing, but entries are printed off and kept in plastic pockets	All referrals and paper handwritten case histories are scanned and attached to the S1 record, any emails, letters from patients etc are kept in the plastic files.	All paper files are stored in locked cabinets and are stored according to caseloads. On general wards the document summary is put in the medical notes and information updated on the WebV board. At the point of discharge anything that is recorded in the Pts S1 record is removed from the paper file and placed in confidential waste, the remaining paperwork will then be scanned into S1 and the original paper copies destroyed. Old paper files are with Magnum for 8 years before being destroyed.	Adult 8 years
Stroke Unit	Adult	Electronic S1 and paper	Full MDT record paper based and written up on the ward. Initial assessment and case history are scanned from the written records into S1. On discharge the MDT discharge summary is copied to patient and GP, the Stoke Unit section is copied into S1. Any paper generated is kept in paper light notes.	All paper records are retained in a locked cabinet in the MDT office on the Stroke Unit	Adult 8 years
Stroke Community	Adult	Electronic S1 and paper	Paper file from Stroke Unit passed to Stroke Community	Paper file locked in filing cabinet on the Stroke Unit, on discharge all paper records are scanned in to S1 and destroyed	Adult 8 years

Appendix B

Information Governance Alliance IGA

Table 1 - AoMRC medical record keeping standards

Standard Number	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (must include NHS number, may include local ID) and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed[27]
7	Entries to the medical record should be made as soon as possible after the event to be documented (for example change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in a medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion a transfer of care occurs, the consultant responsible for the patient's care will change the name of the responsible consultant and the date and time of the agreed transfer of care
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, and Cardiopulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney

Further information about professional standards for records can be obtained from your relevant professional body. The main standard setting bodies in health and social care in England are noted at Appendix Two.

[27] For paper records a single line through the words must be used so the content remains visible. For electronic records deletions from the medical record must be reversible to prevent fraud.

Information Governance Alliance IGA

Social Care and Public Health Records

The DH is the government department with responsibility for oversight of NHS and adult social care delivery. The Department for Education remains responsible for the oversight of children's social care.

This Code is designed to support the integration of health and adult social care provision. The Code applies to areas of health and social care integration, such as jointly held care records, in addition to other health care records which may be held by local authorities, such as public health records and contraceptive and sexual health services records. These services are now commissioned by public health departments in local authorities, but are essentially health care records.

Management and Organisational Responsibility

The records management function should be recognised as a specific corporate responsibility within every organisation. It should provide a managerial focus for records of all types in all formats, including electronic records, throughout their lifecycle from creation through to ultimate disposal. The records management function should have clear responsibilities and objectives, and be adequately resourced to achieve them.

A designated member of staff of appropriate seniority (i.e. Care Home Manager or Practice Manager or in larger organisations board level/reporting directly to a board member) should have lead responsibility for records management within the organisation. This lead role should be formally acknowledged and communicated throughout the organisation.

It is essential that the manager(s) responsible for the records management function are directly accountable to, or work in close association with, the manager(s) responsible for freedom of information, data protection and other information governance work areas.

As records activity is undertaken throughout the organisation, mechanisms must be in place to enable the designated corporate lead to exercise an appropriate level of management of this activity, even where there is no direct reporting line. This might include cross-departmental records and information working groups or individual information and records champions, who may also be information asset owners[28]. It is good practice to use the information asset register to help with managing information.

All staff, whether clinical or administrative, must be appropriately trained so that they are fully aware of their personal responsibilities in respect of record keeping and records management and that they are competent to carry out their designated duties. No patient or client records or systems should be handled or used until training has been completed.

Training should include the use of electronic records systems and it should be done through generic and/or organisation-wide training programmes which can be department or context specific. These should be complemented by organisational policies and procedures and guidance documentation. An example is health records managers who have lead responsibility for patient case notes and who manage the 'records library' and other storage areas where records are kept. Health records managers must have an up-to-date knowledge of, or access to, expert advice on the laws and guidelines concerning

[28] Government SIRO Manual https://www.gov.uk/service-manual/making-software/information-security.html#information-asset-owner or see HSCIC Information risk Management http://systems.hscic.gov.uk/infogov/security/risk

Appendix C

Audit Schedule – Business Groups & Coding/Audit Department

Month	Medicine Group	Surgery Group	Woman & Children's Group	Coding/Audit Department
January	ECC	General Surgery	Gynaecology	Coding Department Audit Department
February	Elderly Medicine	Urology	Paediatric	Coding Department Audit Department
March	Endoscopy Unit	Breast Surgery (DPoW)	Maternity	Coding Department Audit Department
April	Haematology	Colorectal	Oral/Orthodontics	Coding Department Audit Department
May	Diabetes	Upper GI	Paediatrics	Coding Department Audit Department
June	Immunology	Vascular	Maternity	Coding Department Audit Department
July	Cardiology	Orthopaedics	Oral/Orthodontics	Coding Department Audit Department
August	Dermatology	ENT	Paediatrics	Coding Department Audit Department
September	Respiratory	Ophthalmology	Maternity	Coding Department Audit Department
October	Medical Oncology	Oral/Orthodontics	Oral/Orthodontics	Coding Department Audit Department
November	Neurology	Anaesthetics/Pain Management	Paediatrics	Coding Department Audit Department
December	Rheumatology	Day Surgery Unit (DPoW)	Oral/Orthodontics	Coding Department Audit Department
Each Business Group randomly chooses 10 Health Records from any one of that months audit Speciality areas: • Secretaries Office • The Consultants Office • Ward • Outpatient Reception			The Coding and Audit Department randomly chooses 10 Health Records from: • The coding/Audit Department • Audit Viewing Rooms • Coding areas on Wards if appropriate	

When adding an audit on SharePoint, name the audit using the following format:

In the Audit title box: (1. SITE) (2. NAME OF SPECIALITY/UNIT) (3. MONTH, YEAR)

Example: SGH RESPIRATORY FEB 14

Using the above format gives a uniform view on the audit home page table and makes it clear which Group is compliant in line with the schedule.

Audit Schedule – Corporate Health Records Department

Month	Area to Audit
January	SGH – Main Library, Health Records in file DPoW – Clinic pull area and Medico Legal GDH – Clinic pull area
February	SGH – Archive Library DPoW – Prepped Clinic : Medicine GDH – Prepped Clinic : Medicine
March	SGH – 8's and 9's DPoW – Filed Records (Pre-file) GDH – Filed Records (Pre-file)
April	SGH – Annex Library DPoW – Filed Records (Main Library) GDH – Filed Records (Main Library)
May	SGH – DPoW and GDH Holding (across site service area DPoW – Clinic pull area and Medico Legal GDH – Clinic pull area
June	SGH – Reception DPoW – Prepped Clinic : Surgical GDH – Prepped Clinic : Surgical
July	SGH – Medico Legal DPoW – Filing Returns (Pre-file) GDH – Filing Returns (Pre-file)
August	SGH – Splitting DPoW – Filed Records (Annex of Main Library) GDH – Filed Records (Annex of Main Library)
September	SGH – Deceased DPoW – Clinic pull area and Medico Legal GDH – Clinic pull area
October	SGH – Maternity DPoW – Prepped Clinic : Paeds & Gynae (20 of each specialty) GDH – Prepped Clinic : Paeds & Gynae (20 of each specialty)
November	SGH – Pulled Clinics DPoW – Filing Returns (Pre-file) GDH – Filing Returns (Pre-file)
December	SGH – Prepped Clinics DPoW – Filed Records (Main Library) GDH – Filed Records (Main Library)

When adding an audit on SharePoint, name the audit using the following format:

In the Audit title box: (1. SITE) (2. NAME OF DEPARTMENT) (3. MONTH, YEAR)

Example: DPOW HEALTH RECORDS FEB 14

Using the above format gives a uniform view on the audit home page table and makes it clear which Group is compliant in line with the schedule.

Appendix D

Health Records Library Service – Provision of Records & Referral Letters SGH/DPoW/GDH

- The Health Records Library is responsible to provide health records / referral letters to the clinician for attendances **prior** to the **cut off points**
- The SAT Group is responsible to provide health records / referral letters to the clinician for attendances **subsequent** to the **cut off points**
- **The below cut off points are for add-ons to an already populated clinic**
- **Cut off point for adding a WHOLE clinic is 72 hours (3 working days) prior to taking place**

EXTRA PATIENTS ON CLINICS ALREADY POPULATED

If you are adding patients to clinics within the 24 hour period before the clinic date you should

- Email Health Records Supervisors by the below times:
  12.30 for AM appointments
  15.30 for PM appointments

The Library Supervisors can be contacted after the cut off points as an option to ask if there is any flexibility, Supervisors will advise accordingly after assessing workload. Supervisors contact detail:
DPoW: nlg-tr.NLG-DL-GYCorporateManagers@nhs.net **Extensions: 2943/3698/7041**
SGH: shane.bullivent@nhs.net/w.fletcher@nhs.net/l.arrand@nhs.net **Extensions: 2106/3524/2154**
Please contact SGH Supervisors for any GDH queries.

Off Site Clinics (Satellite Locations) Cut off times are sooner than on site clinics as the boxes leave site by van, 8.00 am **the day before the clinic takes place** except Monday clinics (leaves site Friday am)

Cut-off times for Library providing Health Records/referral letters:

Actual Clinic Day	**Cut Off Day + Time**	
Monday	Thursday	15.30
Tuesday	Friday	15.30
Wednesday	Monday	15.30
Thursday	Tuesday	15.30
Friday / Saturday / Sunday	Wednesday	15.30

On Site Clinics

Cut-off times for Library providing Health Records/referral letters:

Actual Clinic Day	**Cut Off Day + Time**	**AM Clinic Appointment**	**PM Clinic Appointment**
Monday	Friday	12.30	15.30
Tuesday	Monday	12.30	15.30
Wednesday	Tuesday	12.30	15.30
Thursday	Wednesday	12.30	15.30
Friday / Saturday / Sunday	Thursday	12.30	15.30

Admissions (TCI's) *Cut-off times for Library providing health records:*		
Day of Procedure	**Provide Admission List**	**Advise Late Add-ons**
Monday	Thursday 9.00 am	Friday 9.00 am
Tuesday	Friday 9.00 am	Monday 9.00 am
Wednesday	Monday 9.00 am	Tuesday 9.00 am
Thursday	Tuesday 9.00 am	Wednesday 9.00 am
Friday / Saturday / Sunday	Wednesday 9.00 am	Thursday 9.00 am

Walk-ins

Walk-ins are when the patient is advised to attend clinic by: GP Surgery/On Call clinician/ECC (A&E) Department/Optician. It is imperative that Receptionist/Health Records Library is advised of the patient detail as soon as possible, with mandatory demographic detail to ensure that the patient is seen and with the correct Health Record.

Contact Main Library Reception: **DPoW: 7323 Zone1/2/3: Ext 7565 Zone 4 Ext: 2920**
SGH: 2499 D Floor : Ext 5021 C Floor Ext: 2433/5744

If paper is handed to a receptionist with the patient detail, this should be on the appropriate Date Collection Form.

A walk-in is not:

Patient advised in core hours by administration staff to come to clinic or a re-book with no capacity – the patient should be booked into the clinic by the relevant SAT team and ensure the Health Records/documentation are available to the clinician in time of patient attending if the appointment has been booked outside the above cut off points.