East Lancashire Hospitals NHS Trust

TRUST WIDE DOCUMENT

Delete as appropriate	**Policy**
DOCUMENT TITLE:	**Clinical Records Policy**
DOCUMENT NUMBER:	**ELHT/C013 Version 5.3**
DOCUMENT REPLACES Which Version	**Version 5.2**
LEAD EXECUTIVE DIRECTOR DGM	**Director of Finance, Information and Planning (SIRO)**
AUTHOR(S): Note should not include names	**Directorate Manager Centralised Outpatients and Administration Services**

TARGET AUDIENCE:	**All Trust Personnel**
DOCUMENT PURPOSE:	The Clinical Records Policy sets out the standards required for clinical record keeping, and details the specific requirements relating to health records management within the organisation to ensure the delivery of an effective high quality clinical records service. This policy also sets out the current legislation relating to health records.
To be read in conjunction with (identify which internal documents)	C134 Subject Access Policy
	• Information Governance Alliance - Records Management Code of Practice for Health and Social Care 2016

SUPPORTING REFERENCES	• Health & Safety Care Act – Duty to Share 2015 • Academy of Medical Royal Colleges – A Clinician's Guide to Record Standards • Care Quality Commission the right information in the right place at the right time (2009) • An organisation with a memory (2000) • Confidentiality : NHS code of practice (2003) • NHS information governance: guidance on legal and professional obligations (2007) • Information security management: NHS code of practice (2007) • A question of balance: independent assurance of information governance returns(2010) • Information governance toolkit • Nursing and midwifery council (2009) Record Keeping: guidance for nurses and midwives • Department of Health (2010) Essence of care benchmarking for record keeping • Royal College of Physicians (2008) a clinician guide to record standards part 1 & 2 • Royal College of Physicians (2009) generic medical record keeping standards • waste management policy C071 V4.1 • Information Governance Alliance, Record Management Code of Practice for Health & Social Care 2016

CONSULTATION		
	Committee/Group	**Date**
Consultation	Health Records Steering Group reports to Quality & Safety Board	April 2018
Approval Committee	Health Records Steering Group	April 2018
Ratification date at Policy Council:	May 2018	
NEXT REVIEW DATE:	April 2021 (or sooner if necessary due to the pending electronic patient record, changes in legislation etc)	
	V5 - Policy updated to reflect inclusion of community records following transfer of community services. V5.1 – Policy updated to reflect titles/meetings changes V5.2 – Policy updated to reflect the introduction of the	

AMENDMENTS:	Information Governance Alliance, Record Management Code of Practice for Health and Social Care 2016 following the withdrawal of the DOH Records Management Code of Practice Parts 1 & 1. Title changes Approval of clinical documentation within the Trust Inclusion of the HRSG Terms of Reference V5.3 – Policy updated to reflect the following changes: - guidance in relation to the destruction of patient records in light of the Independent Enquiry into Child Sexual Abuse (IICSA) - TOR Health Records Steering Group - Clinical Audit Schedule - Introduction of General Data Protection Act (GDPR) in relation to Subject Access Requests

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Appendices

CLINICAL RECORDS POLICY

1. Objectives of this Policy

The key objective of this policy is to ensure that a comprehensive and secure clinical records management system is in place in the Trust, and that there is a process for managing the risks associated with clinical records in all media. This policy sets out the duties, standards, managerial responsibilities and minimum retention periods for the effective management of all clinical records. This includes the creation, day to day use, storage, and maintenance and disposal procedures.

Clinical records include all clinical information relating to a patient in whatever media this is available. These may include:

- Electronic or paper-based patient health records including all specialties
- Urgent care and emergency, birth and all other registers;
- Theatre records and related registers;
- Radiology and imaging reports, output and images;
- Photographs, slides and other images;
- Audio and video tapes, cassettes, CD-ROMs
- Computerised records

Clinical Records may be referred to as:

- Medical records
- Patient records/notes
- Speciality/departmental records or assessments
- Casenotes
- Health records
- Obstetric health records
- Urgent care and emergency card

They inform the clinician of all key features which might influence the treatment proposed. They also provide a contemporaneous and complete record of the patient's treatment and related features.

In addition to ensuring good patient care, complete, accurate and timely records allow a clear picture of events to be obtained, which is imperative for managing claims and complaints, and for auditing practice and remaining proactive.

2. Duties and Accountability

2.1. Chief Executive

The Chief Executive is accountable for the quality of records management within the Trust and exercises this responsibility through delegation to the Director of Finance Information and Planning as Senior Information Risk Officer (SIRO) and via line management to the Director of Diagnostics and Clinical Support Division.

2.2. Directorate Manager, Centralised Outpatients & Administration Services

The Directorate Manager for Centralised Outpatients & Administration Services reports via the Clinical Director for Centralised Outpatients and Administration Services to the responsible Executive Director. She/he will be the organisational lead manager responsible for Clinical Records management, and act as the Information Asset Owner (IAO) for all patient records within the Trust. She/he will facilitate the Health Records Steering Group, and will be responsible for providing exception reports where appropriate to the Patient Safety & Risk Committee. She/He will act as the lead for maintaining and updating the Clinical Records action plan.

2.3. Executive Directors and Divisional Management Teams

They must ensure that:-

- All staff adhere to the policy
- The policy and procedures are carried out for records consistently and appropriately.
- Record keeping standards are monitored through quality control and audit to ensure the effectiveness of the policy
- Appropriate training is given for staff to understand and comply with their responsibilities

2.4. Individual responsibility

All healthcare workers are professionally accountable for maintaining clinical records as defined in this policy. All staff are responsible for any record they create or use, and any records which are created are public records. All staff that come into contact with patient information have a personal common law duty of confidence. Any records identified as lost or missing must be reported as an incident. Any breach of confidentiality will result in consideration of disciplinary action.

2.5 Health Records Steering Group

The Health Records Steering Group is responsible for the implementation and development of the clinical records policy, and to oversee the audit and monitoring of its implementation and action recommendations. The steering group is required to report via its minutes and exception reports to the Patient Safety & Risk Committee which is the overarching operational group for risk management in the Trust

2.6 Quality & Safety Board

The Patient Safety & Risk Committee will receive assurance on progress with the clinical records action plan(s) via the minutes of the Health Records Steering Group, and exception reports on specific issues or concerns from the Health Records Steering Group.

2.7 Clinical Audit

The Clinical Audit and Health Records Departments will undertake the audits as required and will provide these to the Health Records Steering Group for review and production of an action plan.

2.8 Services Records Audit

All Services will be required to audit their clinical records for compliance with this policy and these will be submitted to the Health Records Steering Group for review and production of an action plan.

3. Legal Obligations that apply to records

The main legislative measures that give rights of access to health records include:

- Data Protection Act 1998 to be replaced by Data Protection Act 2018: gives rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf.
- Access to Health Records Act 1990 – gives rights of access to deceased patient health records by specified persons.
- Medical Reports Act 1988 – gives rights for individuals to have access to reports relating to themselves, provided by medical practitioners for employment or insurance purposes.
- General Data Protection Regulations (GDPR), Article 15 gives rights of access to data subjects.

3.1. **Data Protection Act 1998** to be replaced by Data Protection Act 2018

This act regulates the processing of personal data held manually and on computer. It applies to personal information generally not just health records. The Act currently contains three important strands amongst others:

1. The principle of lawful and transparent processing.
2. Compliance with the 6 data protection principles
3. Observing the rights of data subjects

3.2. Patient Access to Records

The Data Protection Act & General Data Protection Regulations (GDPR) gives the right of individuals, or their authorised representative to seek access to their records. This must be completed within one calendar month from receipt of request. Please refer to the Subject Access policy. C134.

There are two main exemptions:

1. If the record contains sensitive or personal third party information.

2. If access to all or part of the record will seriously harm the physical or mental wellbeing of the individual or any other person.

Patient access requests must be made to the Access Request Clerks in the Health Records Department, Burnley General Hospital, Burnley. Where the Data Subject makes a Subject Access Request by electronic means, and unless otherwise requested by the Data Subject, the information should be provided in a commonly used electronic format.

Under the General Data Protection Act, any request to viewing or provide copies of the health records of a living person is free of charge unless it is 'manifestly unfound or excessive' (especially if it is repetitive). If further copies are required, a reasonable fee based on administrative costs can be applied. This will be set out in the Subject Access policy, C134. This will now include not charging access to health records for deceased patients.

3.3. Access to Health Records Act 1990

The Access to Health Records Act now only affects the health records of deceased patients. It applies only to records created since 1 November 1991. The Act gives access to:

- the deceased's personal representatives (both executors or administrators) to enable them to carry out their duties: and
- anyone who has a claim resulting from the death.

However, this not a general right of access, it is a restricted right and the following circumstances could limit the applicant's access:

- if there is evidence that the deceased did not wish for any or part of their information to be disclosed; or
- if disclosure of the information would cause serious harm to the physical or mental health of any person; or
- if disclosure would identify a third party (i.e. not the patient nor a healthcare professional) who has not consented to that disclosure.

As with the Data Protection Act, a medical professional may be required to screen the notes before release.

Under the Act, if the record has not been updated during the 40 calendar days preceding the access request, access must be given within 21 days of the request. Where the record concerns information all of which was recorded more than 40 calendar days before the application, access must be given within 40 calendar days, however, the Trust will endeavour to supply the information within 21 days.

3.4. NHS Trust Sexually Transmitted Diseases Directions 2000

Every NHS Trust must take all necessary steps to ensure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except:

- For the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof; and
- For the purpose of such treatment or prevention.

3.5. Common Law Duty of Confidentiality

The general rule is that information cannot normally be disclosed without the patient's consent. There are exceptions to this rule

- where disclosure is in the public interest, and
- where there is a legal duty to do so, for example a court order

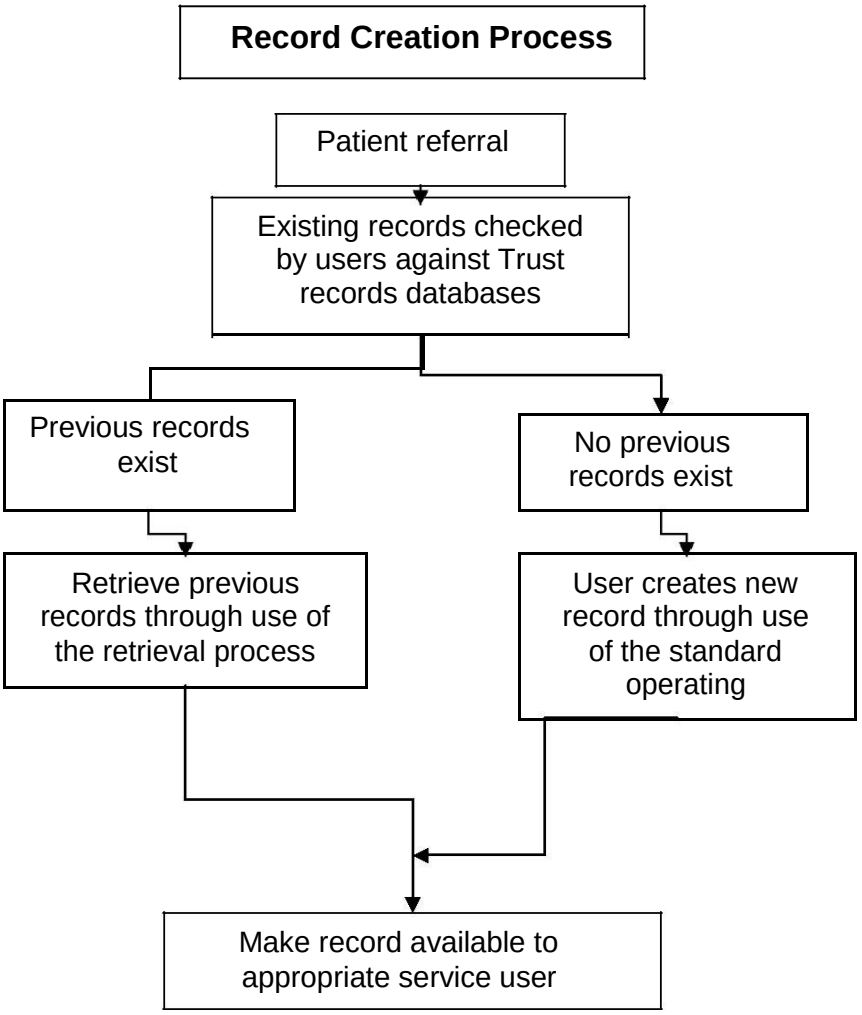
All such requests must be made to the Health Records Manager, Head of Patient Administration or Caldicott Guardian.

4. Creating records

Patient records should be created and aligned to the Trust's Acute Patient Administration System and/or the Community Patient Administration System. These records must include the Trust's Patient Administration System unique reference number and/or the patient's NHS number. These two systems are the master source of information for patient activity within the Trust.

All records created within the Trust should be arranged in a record keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information. Records may be retained in paper or electronic format but the same referencing system must apply.

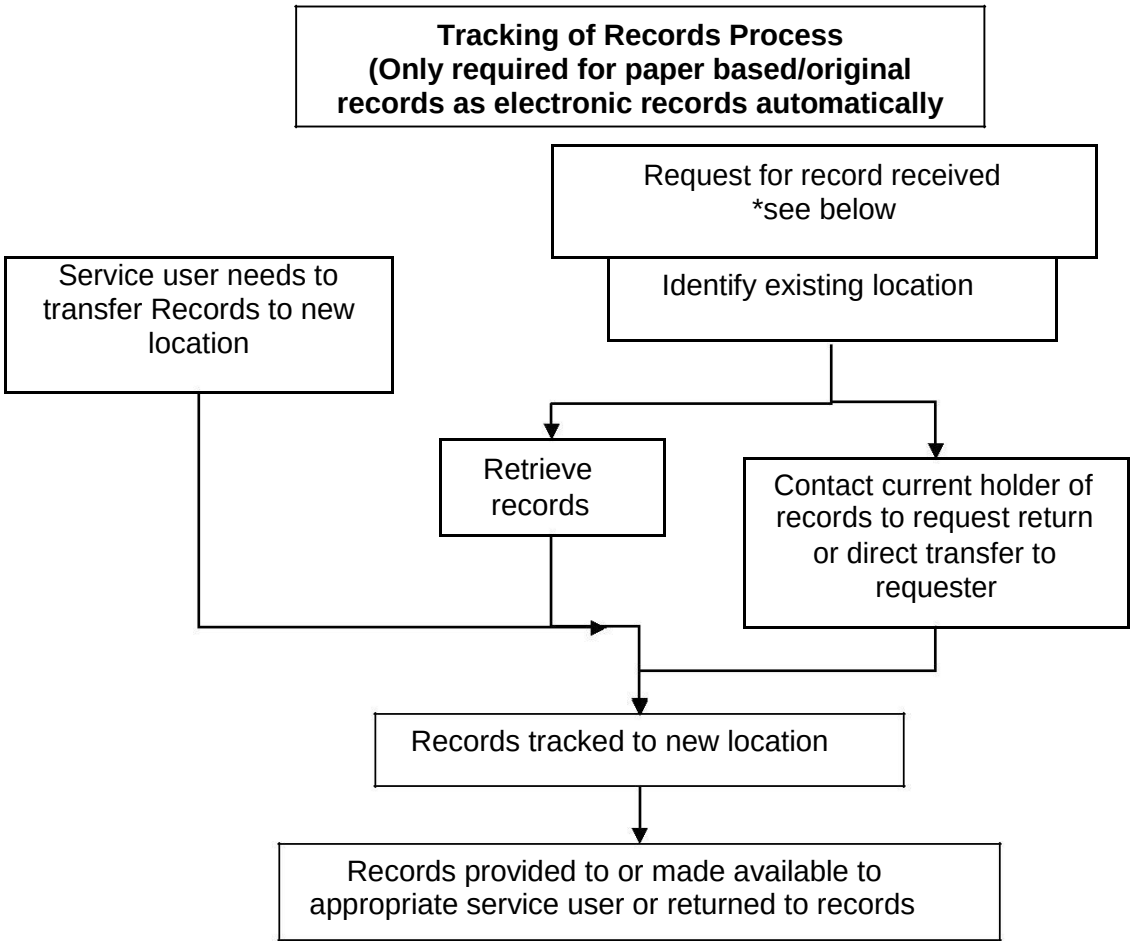
Process for Creating Records – How a new record is created



5. Tracking Records

The movement and location of records must be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions. Record tracking is only applicable to paper and other original records.

Process for tracking records



***Casenote tracking system**

6. Casenote Tracking System

The PAS system is used to electronically track patient casenotes. This enables Trust staff on all hospital sites to accurately identify the physical location of Casenotes and track their movements through the transfer facility within the casenote tracking (CNT) functionality.

Following a request made to the appropriate records library or department by telephone/email/writing. The staff receiving the request for records must establish that the person making the request has the authority to view the record and is only doing so with good cause. Unavailability of casenotes for clinic or inpatient attendance presents a clinical risk to the patient and therefore must be avoided wherever possible. The ward / department of residence will be the tracked location. Casenotes for patients going to theatre, x-ray or other diagnostic service will not require tracking as they will remain with the patient or escort.

No other method of tracking should be used for casenotes. If PAS is unavailable the Health Records Department must be contacted and Business Continuity Plans will be implemented in accordance with Emergency Planning

6.1. Authorised Borrowers

It is the responsibility of all Managers to ensure that staff input the relevant Casenote Tracking information in order to maintain a comprehensive and up to date system. This includes keeping the details of Authorised Borrowers up to date. Managers have full responsibility for ensuring that the list of Authorised Borrowers associated with their area of work is reviewed and kept up to date. The relevant updates and changes must then be forwarded to the Assistant Health Records Manager based at Royal Blackburn Hospital (RBH) on a monthly basis.

6.2. Storage Locations

It is the responsibility of all Managers to ensure that staff input the relevant casenote tracking information in order to maintain a comprehensive and up to date system. This includes keeping the details of current Storage Locations up to date including off-site storage. Managers have full responsibility for ensuring that the list of storage locations associated with their area of work is reviewed and kept up to date. The relevant updates and changes must then be forwarded to the Deputy Health Records Manager based at Royal Blackburn Teaching Hospital (RBTH) on a monthly basis.

6.3 Loaning of Casenotes to Authorised Borrowers

Health Records library staff will be responsible for the completion of the loan case note information. Library staff must complete the loan date and expected return date associated with each individual set of casenotes. Library staff will also enter the requesting authorised borrower details and storage location details of the casenotes.

6.4. Transferring of Casenotes to Authorised Borrowers (non ELHT Hospitals)

Original records must NOT be sent to any other organisation without prior approval from Health Records, with the exception of Salford Royal Hospital and Royal Bolton Hospital. If it is deemed clinically essential the casenote must be tracked to the receiving person, ward and hospital.

6.5. Returning of Casenotes to Main Storage Location

The authorised borrower of a casenote is responsible for transferring the casenotes back to the main storage location before or on the expected return date. Notes must not be kept in authorised borrowing storage locations for more than 4 weeks, unless the patient is expected to return to the clinic/ward within a 1 week period. The authorised borrower must return the casenotes to a transit location. Library staff will then return the physical casenotes to a specified storage location within the health records libraries/Off-site storage location. Health Records staff will be responsible for ensuring the casenotes storage location is updated once the physical casenotes are received and filed.

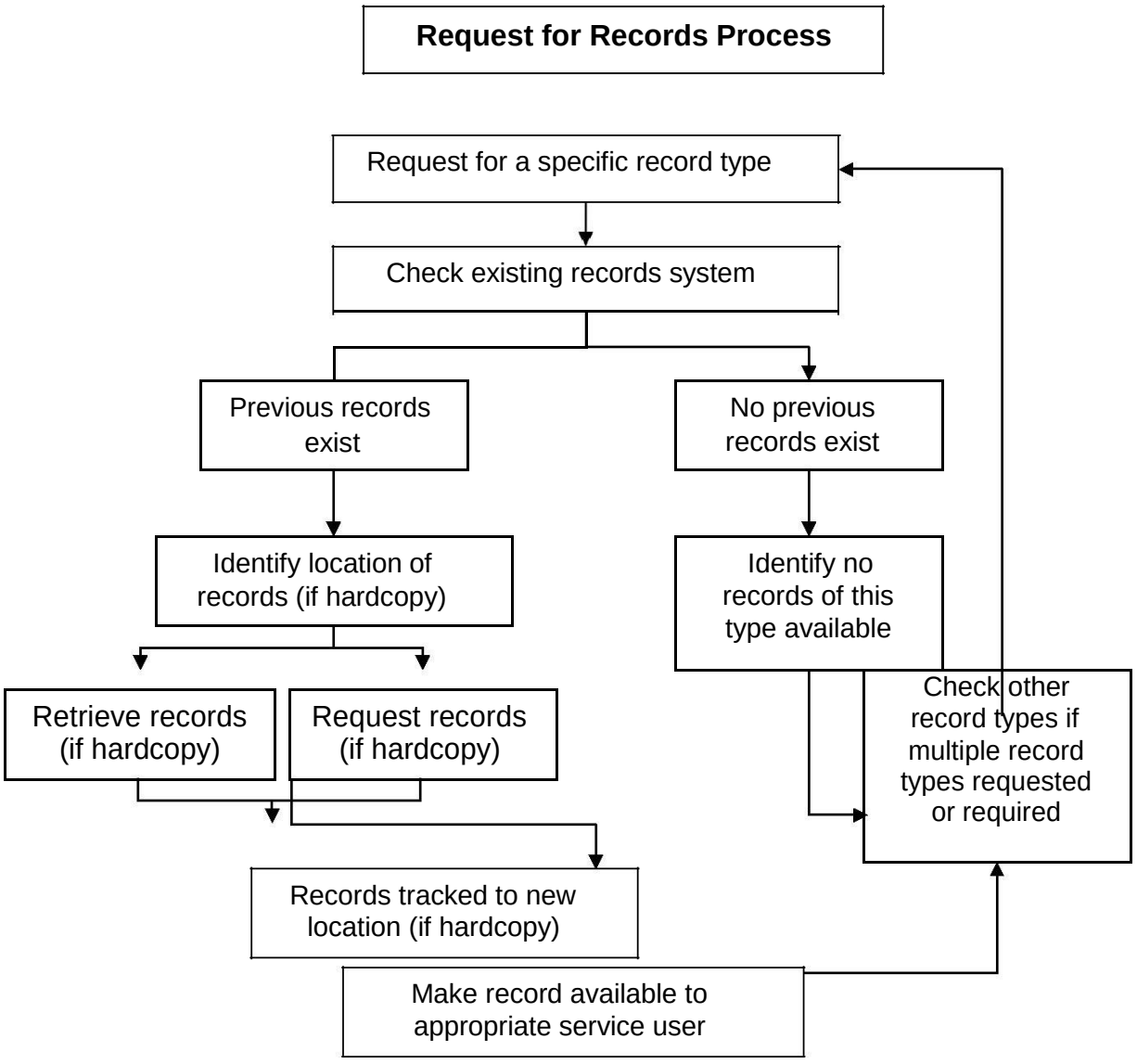
All staff are responsible for the maintenance of comprehensive and orderly casenotes whilst in their care. This means that all loose filing, nursing notes, discharge letters and reports must be filed inside the casenote folder, in the appropriate order at the point of care.

7. Retrieving Records

The record keeping system, where paper or electronic, should include a documented set of rules for referencing, titling, indexing and if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information when it is needed and to maintain security and confidentiality.

Digital information must be stored in such a way that throughout the lifecycle it can be recovered in an accessible format in addition to providing information about those who have accessed the record.

Process for Retrieving Records



8. Systems for Alerting

Each paper record must allow for the provision of a system to alert clinicians to all identified allergies and alerts recorded on the hospital casenote.
In the event that allergies and alerts are identified in departmental record systems, these must then be recorded in the hospital casenote if one exists.

Each individual system/departmental record should have a documented approach for recording its activities, including creation, retrieval, tracking, retention, disposal and destruction of the records created.

For hospital based inpatient and outpatient and emergency care records, where the acute Patient Administration System and the Electronic Patient Tracking Systems are the main reference systems, the hospital casenote and emergency card will be the main record source.

Speciality records may be held locally to support local clinical protocols where close access is

required to a patient's treatment notes e.g. obstetrics, orthodontics, and physiotherapy. Other departments/ areas where records are created must hold their own documented approach detailing the operational policies for the management of their clinical records.

9. The Five Basic Record Keeping Standards required by the Trust to be used by all staff - as a minimum the Trust requires all staff to adhere to the following basic records keeping standards.

1. A unique patient identifier must be used in all records.
2. All entries must be made in chronological order, or if written retrospectively this must be noted – electronic records show timelines and chronology in summary
3. All entries must be written in black ink (does not apply to electronic records)
4. All entries must be signed, and dated or listed to a chronological identifiable date. For electronic records a unique login or e-signature are accepted.
5. All alterations must be made in a way so that the original documentation and alteration are clear and all alterations must be signed and dated.

10. Good Practice Guidelines

In order to provide comprehensive accurate and clear records, staff should conform to their professional guidelines e.g.

- Keep clear, accurate and legible records, reporting the relevant clinical findings, the decision made, the information given to patients, and any drugs prescribed or other investigation or treatment.
- Make records at the same time as the events you are recording or as soon as possible afterwards.
- Only use abbreviations that follow common conventions.
- Accurately date and time records using the 24 hour clock.
- Do not use meaningless phrases, irrelevant speculation, offensive subjective statements or irrelevant personal opinions regarding the patient/service user.

(Ref: Academy of Medical Royal Colleges – A Clinician's Guide to Record Standards)

11. Contemporaneous record

Following the retrieval, receipt and completion of records into a clinical care document, the clinical record should reflect the continuum of patient care and should be viewable in chronological order.

In operational areas records may be divided and current records filed in ring binders. These are acceptable as long as they are filed in chronological order in the patient's main record following discharge. Recording of information held in one part of the record does not have to be duplicated.

12. Retention, Disposal and Destruction

12.1. Retention

The Trust will use as a minimum the Department of Health's Records Retention Schedule (Appendix 3 Related to Health Records). This appendix details the minimum retention period for each type of health record issued by the NHS Code of Practice for Records Management.

Clinical records may be retained for permanent preservation, or retained for research or litigation purposes. A formal request must be made by letter or email by the person wishing to retain a record to all record holders on the approved list (see appendix 3). This requirement will be recorded on all existing clinical records and on the relevant PAS system if one is available to ensure that these records are not destroyed.

Electronic records will be retained in line with the retention schedule and must be stored in such a way that throughout the lifecycle it can be recovered in an accessible format. Retention periods will be reviewed and maintained by the Health Records Steering Group (please refer to appendix 3)

12.2. Disposal

All documents must be reviewed annually in accordance with the Trust's clinical records retention schedule (see appendix 3).

Where records are identified for archival interest, the Directorate Manager must be contacted who will arrange for transfer of custody of these records to the National Archives.

The decision on the transfer of records from paper to electronic and the subsequent destruction of the paper record will be made by the Health Records Steering Group/E-health programme board.

All records which have been archived electronically must be readable and referenced on the appropriate system. Access can be obtained to these records by contacting the appropriate department.

12.3. Temporary Suspension of the destruction of Health Records

The Independent Inquiry into Child Sexual Abuse (IICSA) chaired by Professor Alexis Jay has requested that large parts of the health and social care sector do not destroy any records that are, or may fall into, the remit of the inquiry. Investigations will take into account a huge range of records which may include, but are not limited to, adoption records, safeguarding records, incident reports, complaints and enquiries. Outside of this inquiry, it is also important to consider that these records are likely to require longer than the standard retention periods given in this Code. Before any records are destroyed you are advised to check for any further update from the inquiry website at www.iicsa.org.uk.

Following the above directive, the Trust has made a decision to postpone the destruction of all health records during this investigation, which will be reviewed on a quarterly basis, based on the progress of the inquiry.

12.4. Destruction

Documents must be destroyed confidentially either by use of a local cross cut shredder or using the approved confidential waste removal contractor. – Please refer to the Trust Waste Management Policy C071 V4.1

Where records are destroyed by an external company, eg approved storage companies, a record of the destruction of the records showing their reference, description and date of destruction must be received and retained by the service.

13. Records Security and Storage

All staff are responsible for the safe-keeping of all records which they handle. When out of file all records must be kept secure at all times and all offices where records are stored must be locked. It

is the responsibility of each departmental manager to ensure appropriate access is available to any records required out of hours. A privacy impact assessment should be conducted on the offsite storage providers.

14. Records Security Standards

1. Clinical records contain confidential information, and it is therefore vital that confidentiality is safeguarded at every stage of the lifecycle of the record.

2. Clinical records must only be accessed for clinical purposes, approved research protocols, clinical audit, complaints investigation and litigation.

3. Original records should not be sent to any other organisation without prior approval.

4. Clinical records transferred by hospital employees, must be placed in a sealed envelope or approved system for secure transportation.

5. Clinical records transferred by non-hospital employees must be undertaken by appropriate approved systems or contractors and should be transferred in sealed and tamperproof containers/envelopes.

6. Staff taking clinical records off premises must accept responsibility for their safe keeping maintaining confidentiality.

7. Handheld records must be retrieved from the patient/service at the last contact. Systems must be in place for staff to obtain the handheld record from the patient following treatment.

8. All staff who use clinical records must be fully aware of their personal responsibilities and undertake regular training. (see Information Governance Toolkit and the Information Governance policy)

9. Records identified as lost or missing must be reported immediately to your line manager and if still identified as missing via an Incident report form. The Health Records department should be contacted for advice on further actions.

10. In the unlikely event that records are identified as sent to the wrong address all reasonable methods of recovering these documents must be made. This will include contacting the postal service provider, or courier, and must include consideration of a staff member(s) going to the address to recover the information in person. Reasons for not undertaking any actions must be documented on the incident investigation section of the incident report.

15. Training and Development

Training on Record Keeping is mandatory for all Trust staff. This is included in the Information Governance Toolkit for all Trust staff and reflected in Trust Policy (HR42), monitoring of this is audited in Mandatory Training policy.

Record keeping guidance is available for reference in all services/wards, and regular updates on clinical records issues are provided via message of the day and departmental/Information Governance newsletters.

16. Process for Monitoring Compliance of this Policy

The effective implementation of this policy will be monitored through a process of internal audits. These audits will be undertaken regularly to ensure compliance with this policy. See appendix 2 for the audit schedule.

The audit reports will as a minimum include:-

- methodology
- findings
- recommendations
- action plan

The outcome of all records audits will be reported to the Health Records Steering Group who will agree the action plan and include actions in the Trust Clinical Records Action Plan. The Health Records Steering Group will monitor this plan to ensure that all recommendations have been actioned appropriately.

All audit reports submitted to the Health Records Steering Group will be reviewed at least once each calendar year to monitor whether the format for audit reports has been achieved. This audit will be presented to the Health Records Steering Group and will monitor whether actions plans have been reviewed. If any deficits are identified, the Trust's clinical records action plan will be updated accordingly.

The process for monitoring the HRSG is via the Patient Safety & Assurance Risk Committee – see appendix one for the Terms of Reference.

17. Introduction/Revision of Clinical Documentation for inclusion in the hospital record

- Trust Wide Clinical Documentation used in more than one Division requires approval at the HRSG.
  Specific Divisional Clinical Documentation requires approval at the Divisional Quality and Safety Board only.

Appendix 1

HEALTH RECORDS STEERING GROUP

TERMS OF REFERENCE

CONSITUTION:

The Patient Safety & Risk Assurance Committee has approved the establishment of the Health Records Steering Group for the purpose of:

- Setting standards for health records documentation including casenote architecture and documentation for inclusion in the casenote, and work in conjunction with Directorates to promote safe personal and effective casenote provision.
- Ensure that Health Records audits are undertaken on a regular, systematic basis and that action plans are generated, approved and monitored by the Health Records Steering Group. Unresolved issues will be escalated to the Divisional Quality Safety Boards.
- Ensure that the Trust is compliant with Information Governance regulations and implement changes to policy, procedures and processes as required in relation to health records.
- To ensure the provision of a high quality Health Records Service for the Trust and the wider Health Community.
- To facilitate and support the development of the Electronic Health Record Trust-wide and manage transition from paper to electronic.
- Facilitate continuity of care by the effective and efficient transmission of information between Clinicians using the health record, regardless of the media on which it is held.
- Monitor the Health Records Service to ensure that the overall objectives of the Trust and the wider Health Community are met and that the Trust complies with professional good practice, current legislation, national policies and guidelines.
- Develop policies and procedures relating to the Health Records Service, regularly review those policies and amend them as appropriate. Ensure that all staff is aware of the policies and procedures and that appropriate training is provided.
- Develop, implement and regularly monitor and manage standards for the Health Records Service and ensure that compliance with the standards is reported regularly to the Trust Board.
- Support the development of multi-disciplinary records in both paper and Electronic Health Record.
- Support the Health Records Service and Clinical Divisions on a continuing basis to ensure compliance with NHS Improvement Records Management standards from various bodies.

DUTIES

In particular the group will:

Be the guardian of the patient health care record in ensuring that they are fit for purpose for the provision of providing safe, personal and effective health care to our patients. To receive and review outputs from audits undertaken and ensure that recommendations are implemented in a timely manner. Provide support and guidance as required to members of the public and staff.

MEMBERSHIP:

- Consultant - Chair
- Directorate Manager - Centralised Outpatients and Administration Services (Convenor)
- Divisional Directors to nominate representatives from each specialty
- Health Records and Outpatient Reception Manager & Deputy
- I M & T Training Lead
- Medical Secretarial Representative x 2
- Ward Clerk Representative
- Head of Information Governance
- Chief Clinical Information Officer
- Chief Nurse Information Officer
- Clinical Audit Manager, Quality and Safety
- Divisional Quality & Safety Leads (Invite by exception only)

ATTENDANCE

The Chair of the group may also extend invitations to other personnel with relevant skills, experience or expertise as necessary either to observe or to deal with particular items of business on the agenda.

RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the group have a responsibility to:

- attend or nominate a deputy for all meetings, having read all papers beforehand;
- act as ‘champions’, disseminating information and good practice as appropriate;
- identify agenda items, for consideration by the Chair at least 10 days before the meeting;
- prepare and submit papers for a meeting, at least 5 clear working days before the meeting;

- when matters are discussed in confidence at the meeting, to maintain such confidences;

- declare any conflicts of interest / potential conflicts of interest in accordance with the East Lancashire Hospitals NHS Trust's policies and procedures;

FREQUENCY OF MEETINGS:

Minimum of quarterly

QUORUM

25% of members of which Chairman, Health Records Representative, 1 Divisional Quality & Safety Lead, 1 Clinical Representative and 1 Quality and Safety Representative need to be present.

DECISION MAKING

Wherever possible members of the group will seek to make decisions and recommendations based on consensus.

- Where this is not possible then the Chair of the meeting will ask for members to vote using a show of hands, provided that nothing in the way of business is conducted is prohibited by the standing orders of the East Lancashire Hospitals NHS Trust.

- In the event of a formal vote the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

- Only the members of the group present at the meeting will be eligible to vote. Members not present, non-voting deputies and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

- The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this group

DISTRIBUTION OF MINUTES

- All members of the group
- Patient Safety and Risk Assurance Committee
- Minutes archived on V: Drive in Health Records Steering Group folder.

PROCESS FOR MONITORING EFFECTIVENESS

Via Patient Safety and Risk Assurance Committee

REPORTING ARRANGEMENTS TO:

The Health Records Steering Group will report to the Patient Safety and Risk Assurance Committee

REVIEW
Terms of Reference will normally be reviewed annually, with recommendations on changes submitted to the Group approval.

Date Approved and issued:	February 2018
Version Number:	1
Next Review:	February 2019
To be reviewed by:	Health Records Steering Group
To be approved by:	Patient Safety and Risk Assurance Committee

Appendix 2 CLINICAL RECORDS AUDIT SCHEDULE – Amended to reflect new audit timetable

STANDARD	MONITORING PROCEDURE	DOCUMENTATION	WHO	MINIMUM FREQUENCY
Legal Obligations	Datix subject access report	Datix subject access report	Access Clerks/Datix Reporting	Once every calendar year
***Disposal* & Destruction Audit**	Casenotes - An Audit of casenotes for disposal will be undertaken to see that records due for disposal in the preceding year were disposed of and whether a record of disposal showing the reference description and date was maintained in accordance with the policy requirements.	Retention & Disposal Audit including disposal certificate	Health Records Manager	Once every calendar year
Retrieval Availability Audit	Casenote Retrieval Availability audits will be performed for all patients attending outpatient clinics. This is recorded on PAS as part of clinic reception function.	PAS Record Casenote Availability Audit reports	Outpatient Information Staff Records Leads	Once every calendar year (Monthly availability reports will be produced for monitoring purposes)
Retrieval Availability Audit	Sample of elective and emergency admissions	PAS Record Casenote Availability Audit reports	Clinical Audit Report to HRSG	Ad-hoc (as and when required)
Continuous Quality Improvement Monitoring	Ward based Quality Improvement Audit to be undertaken collaboratively between junior doctors and ward clerks (encompass Recent Care & Documentation, basic record keeping standards, records storage and access on the wards, filing and casenote quality)	Continuous quality improvement monitoring reports	Divisional representative Reports to Health Records steering Group	Every Forth month
Annual Report on Records Management Audit	All audits submitted to HRSG are monitored to ensure they are compliant with Trust policy	Audit compliance in Trust policy	Health Records Manager	Once every calendar year
Casenote Archive Volume Management	Sample audit on 25 archived casenotes to quality assure Trust policy on archive volume management	Volume Management Checklist Audit	Health Records Department	Ad-hoc (as and when required)

Records Tracking	Casenote Tracking Audit will be undertaken on a needs basis only and reflect all clinical divisions. Casenotes will be checked against PAS to establish that they are appropriately tracked. The audit will identify if borrowers are returning casenotes within agreed timescales	Casenote Tracking Audit Report	Health Records Department	Ad-hoc (as and when required)

Appendix 3 - Health Records Retention Schedule
See Section 12.3. Regarding the temporary suspension of the destruction of health records

This retention schedule details a **Minimum Retention Period** for each type of health record. Records may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. Where a period longer than 30 years is required eg. to be preserved for historical purposes or for any pre-1948 records, the Health Records Manager should be informed who will contact the National Archives. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

Where an organisation has an existing relationship with an approved Place of Deposit, it should consult the Place of Deposit in the first instance. Where there is no pre-existing relationship with a Place of Deposit, organisations should consult The National Archives.

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound, and including all records of NHS patients treated on behalf of the NHS in the private healthcare sector):

- patient health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident & Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (ie microfiche/microfilm);audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents.

If viewed in electronic format, the search facility in Word or PDF can be used to search for particular record types.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
1. Care Records with standard retention periods				
Adult health records not covered by any other section in this schedule	Discharge or patient last seen	8 years	Review and if no longer needed destroy	Basic health and social care retention period - check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Adult social care records	End of care or client last seen	8 years	Review and if no longer needed destroy	
Children's records including midwifery, health visiting and school nursing	Discharge or patient last seen	25th or 26th birthday (see Notes)	Review and if no longer needed destroy	Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Electronic Patient Records System (EPR) NB: The IGA is undertaking further work to refine the rules for record retention and to specify requirements for EPR systems	See Notes	See Notes	Destroy	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the Code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they

					should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
General Dental Services records	Discharge or patient last seen	10 Years	Review and if no longer needed destroy		

Record Type	Retention start	Retention period	Action at end of retention period	Notes
GP Patient records	Death of patient	10 years after death - see Notes for exceptions	Review and if no longer needed destroy	If a new provider requests the records, these are transferred to the new provider to continue care. If no request to transfer: • Where the patient does not come back to the practice and the records are not transferred to a new provider the record must be retained for 100 years unless it is known that they have emigrated • Where a patient is known to have emigrated records may be reviewed and destroyed after 10 years • If the patient comes back within the 100 years, the retention reverts to 10 years after death.
Mental Health records	Discharge or patient last seen	20 years or 8 years after the patient has died	Review and if no longer needed destroy	Covers records made where the person has been cared for under the Mental Health Act 1983 as amended by the Mental Health Act 2007. This includes psychology records. Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer than 20 years where the case may be ongoing. Very mild forms of adult mental health treated in a community setting where a full recovery is made may consider treating as an adult records and keep for 8 years after discharge. All must be reviewed prior to destruction taking into account any serious incident retentions.
Obstetric records, maternity records and antenatal and post natal records	Discharge or patient last seen	25 years	Review and if no longer needed destroy	For the purposes of record keeping these records are to be considered as much a record of the child as that of the mother.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
2. Care Records with Non-Standard Retention Periods				
Cancer/Oncology - the oncology records of any patient	Diagnosis of Cancer	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit	For the purposes of clinical care the diagnosis records of any cancer must be retained in case of future reoccurrence. Where the oncology records are in a main patient file the entire file must be retained. Retention is applicable to primary acute patient record of the cancer diagnosis and treatment only. If this is part of a wider patient record then the entire record may be retained. Any oncology records must be reviewed prior to destruction taking into account any potential long term research value which may require consent or anonymisation of the record.
Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM)	Discharge or patient last seen	8 or 10 years (see Notes)	Review and if no longer needed destroy	Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction taking into account any serious incident retentions. If this is a record of a child, treat as a child record as above.
HFEA records of treatment provided in licenced treatment centres		3, 10, 30, or 50 years	Review and if no longer needed destroy	Retention periods are set out in the HFEA guidance at: http://www.hfea.gov.uk/docs/General_directions_0012.pdf
Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)	Diagnosis	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit	For the purposes of clinical care the diagnosis records of CJD must be retained. Where the CJD records are in a main patient file the entire file must be retained. All must be reviewed prior to destruction taking into account any serious incident retentions.

Record of long term illness or an illness that may reoccur	Discharge or patient last seen	30 Years or 8 years after the patient has died	Review and if no longer needed destroy	Necessary for continuity of clinical care. The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life long illness.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
3. Pharmacy The IGA are conducting further work to expand this section which will be updated in the near future. As an interim measure you can view a list of Pharmacy records and their associated retention periods and actions by clicking on this link to the NHS East and South East Specialist Pharmacy Services retention schedule.				
Information relating to controlled drugs	Creation	See Notes	Review and if no longer needed destroy	NHS England and NHS BSA guidance for controlled drugs can be found at: http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx and https://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf The Medicines, Ethics and Practice (MEP) guide can be found at the link (subscription required): http://www.rpharms.com/support/mep.asp Guidance from NHS England is that locally held controlled drugs information should be retained for 7 years. NHS BSA will hold primary data for 20 years and then review. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/
Pharmacy prescription records. See also **Information relating to controlled drugs.**	Discharge or patient last seen	2 Years	Review and if no longer needed destroy	There will also be an entry in the patient record and a record held by the NHS Business Services Authority. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/

Record Type	Retention start	Retention period	Action at end of retention period	Notes
4. Pathology				
Pathology Reports/Information about specimens and samples	Specimen or sample is destroyed	See Notes	Review and consider transfer to a Place of Deposit	This Code is concerned with the information about a specimen or sample. The length of storage of the clinical material will drive the length of time the information about it is to be kept. For more details please see: https://www.rcpath.org/resourceLibrary/the-retention-and-storage-of-pathological-records-and-specimens--5th-edition-.html Retention of samples for clinical purposes can be for as long as there is a clinical need to hold the specimen or sample. Reports should be stored on the patient file. It is common for pathologists to hold duplicate reports. For clinical purposes this is 8 years after the patient is discharged for an adult or until a child's 25th birthday whichever is the longer. After 20 years for adult records there must be an appraisal as to the historical importance of the information and a decision made as to whether they should be destroyed of kept for archival value.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
5. Event & Transaction Records				
Blood bank register	Creation	30 Years minimum	Review and consider transfer to a Place of Deposit	
Clinical Audit	Creation	5 years	Review and if no longer needed destroy	
Chaplaincy records	Creation	2 years	Review and consider transfer to a Place of Deposit	See also Corporate Governance Records
Clinical Diaries	End of the year to which they relate	2 years	Review and if no longer needed destroy	Diaries of clinical activity & visits must be written up and transferred to the main patient file. If the information is not transferred the diary must be kept for 8 years.
Clinical Protocols	Creation	25 years	Review and consider transfer to a Place of Deposit	Clinical protocols may have archival value. They may also be routinely captured in clinical governance meetings which may form part of the permanent record (see Corporate Records).
Datasets released by HSCIC under a data sharing agreement	Date specified in the data sharing agreement	Delete with immediate effect	Delete according to HSCIC instruction	http://www.hscic.gov.uk/media/15729/DARS-Data-Sharing-Agreement/pdf/Data_Sharing_Agreement_2015v2%28restricted_editing%29.pdf
Destruction Certificates or Electronic Metadata destruction stub or record of clinical information held on destroyed physical media	Destruction of record or information	20 Years	Review and consider transfer to a Place of Deposit	Destruction certificates created by public bodies are not covered by an instrument of retention and if a Place of Deposit or the National Archives do not class them as a record of archival importance they are to be destroyed after 20 years.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
Equipment maintenance logs	Decommission-ing of the equipment	11 years	Review and consider transfer to a Place of Deposit	
General Ophthalmic Services patient records related to NHS financial transactions	Discharge or patient last seen	6 Years	Review and if no longer needed destroy	
GP temporary resident forms	After treatment	2 years	Review and if no longer needed destroy	Assumes a copy sent to the responsible GP for inclusion in the primary care record
Inspection of equipment records	Decommission-ing of the equipment	11 Years	Review and if no longer needed destroy	
Notifiable disease book	Creation	6 years	Review and if no longer needed destroy	
Operating theatre records	End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit	If transferred to a Place of Deposit the duty of confidence continues to apply and can only be used for research if the patient has consented or the record is anonymised.
Patient Property Books	End of the year to which they relate	2 years	Review and if no longer needed destroy	
Referrals not accepted	Date of rejection.	2 years as an ephemeral record	Review and if no longer needed destroy	The rejected referral to the service should also be kept on the originating service file.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
Requests for funding for care not accepted	Date of rejection	2 years as an ephemeral record	Review and if no longer needed destroy	
Screening, including cervical screening, information where no cancer/illness detected is detected	Creation	10 years	Review and if no longer needed destroy	Where cancer is detected see **2 Cancer / Oncology**. For child screening treat as a child health record and retain until 25th birthday or 10 years after the child has been screened whichever is the longer.
Smoking cessation	Closure of 12 week quit period	2 years	Review and if no longer needed destroy	
Transplantation Records	Creation	30 Years	Review and consider transfer to a Place of Deposit	See guidance at: https://www.hta.gov.uk/codes-practice
Ward handover sheet	Date of handover	2 years	Review and if no longer needed destroy	This retention relates to the ward. The individual sheets held by staff must be destroyed confidentially at the end of the shift.

Record Type	**Retention start**	**Retention period**	**Action at end of retention period**	**Notes**
6. Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).				
Recorded conversation which may later be needed for clinical negligence purpose	Creation	3 Years	Review and if no longer needed destroy	The period of time cited by the NHS Litigation Authority is 3 years
Recorded conversation which forms part of the health record	Creation	Store as a health record	Review and if no longer needed destroy	It is advisable to transfer any relevant information into the main record through transcription or summarisation. Call handlers may perform this task as part of the call. Where it is not possible to transfer clinical information from the recording to the record the recording must be considered as part of the record and be retained accordingly.
The telephony systems record (not recorded conversations)	Creation	1 year	Review and if no longer needed destroy	This is the absolute minimum specified to meet the NHS contractual requirement.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
7. Births, Deaths & Adoption Records				
Birth Notification to Child Health	Receipt by Child health department	25 years	Review and if no longer needed destroy	Treat as a part of the child's health record if not already stored within health record such as the health visiting record.
Birth Registers	Creation	2 years	Review and actively consider transfer to a Place of Deposit	Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and offered to a Place of Deposit at the end of this retention period. Information is also held in the NHS Birth Notification Service electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.
Body Release Forms	Creation	2 years	Review and consider transfer to a Place of Deposit	
Death - cause of death certificate counterfoil	Creation	2 years	Review and consider transfer to a Place of Deposit	
Death register information sent to General Registry Office on monthly basis	Creation	2 years	Review and consider transfer to a Place of Deposit	A full dataset is available from the Office for National Statistics.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
Local Authority Adoption Record (normally held by the Local Authority children's services)	Creation	100 years from the date of the adoption order	Review and consider transfer to a Place of Deposit	The primary record of the adoption process is held by the local authority children's service responsible for the adoption service.
Mortuary Records of deceased	End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit	
Mortuary Register	Creation	10 Years	Review and consider transfer to a Place of Deposit	
NHS Medicals for Adoption Records	Creation	8 years or 25th birthday	Review and consider transfer to a Place of Deposit	The health reports will feed into the primary record held by the local authority children's services. This means that the adoption records held in the NHS relate to reports that are already kept in another file which is kept for 100 years by the appropriate agency and local authority.
Post Mortem Records	Creation	10 years	Review and if no longer needed destroy	The primary post mortem file will be maintained by the coroner. The coroner will retain the post mortem file including the report. Local records of post mortem will not need to be kept for the same extended time.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
8. Clinical Trials & Research For clinical trials record retention please see the MHRC guidance at https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials				
Advanced Medical Therapy Research Master File	Closure of research	30 years	Review and consider transfer to a Place of Deposit	See guidance at: https://www.gov.uk/guidance/advanced-therapy-medicinal-products-regulation-and-licensing
Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014	Closure of trial	25 years	Review and consider transfer to a Place of Deposit	For details please see: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.0001.01.ENG
European Commission Authorisation (certificate or letter) to enable marketing and sale within the EU member states area	Closure of trial	15 years	Review and consider transfer to a Place of Deposit	For details please see: http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf
Research data sets	End of research	Not more than 20 years	Review and consider transfer to a Place of Deposit	For details please see: http://tools.jiscinfonet.ac.uk/downloads/bcs-rrs/managing-research-records.pdf
Research Ethics Committee's documentation for research proposal	End of research	5 years	Review and consider transfer to a Place of Deposit	For details please see: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/

Record Type	Retention start	Retention period	Action at end of retention period	Notes
				Data must be held for sufficient time to allow any questions about the research to be answered. Depending on the type of research the data may not need to be kept once the purpose has expired. For example data used for passing an academic exam may be destroyed once the exam has been passed and there is no further academic need to hold the data. For more significant research a Place of Deposit may be interested in holding the research. It is best practice to consider this at the outset of research as orphaned personal data can inadvertently cause a data breach.
Research Ethics Committee's minutes and papers	Year to which they relate	Before 20 years but as soon as practically possible	Review and consider transfer to a Place of Deposit	Committee papers must be transferred to a Place of Deposit as a public record: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/

Addendum 1: Principles to be used in Determining Policy Regarding the Retention and Storage of Essential Maternity Records

British Paediatric Association

Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Joint Position on the Retention of Maternity Records

1. All essential maternity records should be retained. 'Essential' maternity records mean those records relating to the care of a mother and baby during pregnancy, labour and the puerperium.

2. Records that should be retained are those which will, or may, be necessary for further professional use. 'Professional use' means necessary to the care to be given to the woman during her reproductive life, and/or her baby, or necessary for any investigation that may ensue under the Congenital Disabilities (Civil Liabilities) Act 1976, or any other litigation related to the care of the woman and/or her baby.

3. Local level decision making with administrators on behalf of the health authority must include proper professional representation when agreeing policy about essential maternity records.
'Proper professional' in this context should mean a senior medical practitioner(s) concerned in the direct clinical provision of maternity and neonatal services and a senior practising midwife.

4. Local policy should clearly specify particular records to be retained AND include detail regarding transfer of records, and needs for the final collation of the records for storage. For example, the necessity for inclusion of community midwifery records.

5. Policy should also determine details of the mechanisms for return and collation for storage, of those records which are held by mothers themselves, during pregnancy and the puerperium.

List of Maternity Records to be retained

6. Maternity Records retained should include the following:

6.1 documents recording booking data and pre-pregnancy records where appropriate;

6.2 documentation recording subsequent antenatal visits and examinations;

6.3 antenatal in-patient records;

6.4 clinical test results including ultrasonic scans, alpha-feto protein and chorionic villus sampling;

6.5 blood test reports;

6.6 All intrapartum records to include, initial assessment, partograph and associated records including cardiotocograph

6.7 Drug prescription and administration records;

6.8 Postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.