University Hospitals of Leicester

NHS Trust

Health Records Management Policy

(Formerly known as the Information (Records) Management Policy and the Records Management Policy)

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Contents

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Version	Date	Author	Change
V2	October 2005	GL	Approval by the Policy and Guideline Committee
V3	January 2007	GL	The main change is the movement of the document from procedure to policy status. Section 4.4 is new. This indicates how the policy will be implemented. Removal of 6.2 Reference to Directorate Links.
V3.1	February 2007	GL	Add in requirement for Records Group attendance 6.3 Insertion of 6.2 highlighting responsibilities of General Managers
V3.2	February 2007	GL	Following PGC Review. Add link to research governance 4.4. 11. para 1 expand on auditing and compliance requirements
V4	March 2010	GL	Complete rewrite to fall in the DoH Records Management Roadmap guidance
V5	November 2011	JL	Review, restructure and update incorporating corporate and healthcare records procedures as appendices
V5.1	January 2013	JL / RS	Update to joint ownership following responsibility changes and slight amendments
V5.2	March 2015	JL	Review and update - Minor changes to job titles, organisation structure to CMG's, inclusion of EDRM
V6	December 2019	DW	Removal of corporate records sections, minor updates to job titles and responsibilities, removal of EDRM information, GDPR updates
V7	December 2022	DW	Removal of references to records retention policy B10/2004. Inclusion of health records retention information in Appendix H. Inclusion of Access to Health records guidance Appendix I Updated following new NHS records management code of practice guidance 2021 inclusion of adoption and transgender records procedures Appendix J and K

Key Words: Records, AHR, access to health, medical records, healthcare records

1 INTRODUCTION

1.1 Records Management is the process by which an organisation manages all the aspects of information whether internally or externally generated and in any format or media type, from their creation, all the way through to their lifecycle to their eventual disposal.

1.2 All health and care employees are responsible for managing records appropriately. Records must be managed in accordance with the Law. Health care professionals also have professional responsibilities, for example complying with the Caldicott principles and records keeping standards set out by registrant bodies.

1.3 The Records Management: NHS Code of Practice© 2021 (hereby known as the Code) has been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. The code provides a framework for consistent and effective records management based on established standards. It includes guidelines on topics such as legal, professional, organisational, and individual responsibilities when managing records. There are numerous types of records in differing formats covered by the Code including:

- Health and care records
- Registers e.g. birth, death, theatre registers
- Xray imaging reports including the images themselves

Examples of records formats that should follow the guidelines are:

- Paper
- Digital
- Photographs, slides or other images
- Microfilm/microfiche/microform
- Physical records made of physical material such as plaster or other types of moulds
- Audio and video tapes, CD-ROM, cassettes etc
- Emails
- Scanned records
- Text messages both outgoing and incoming

1.4 As well as applying to all staff this document sets out a framework within which the staff responsible for managing the Trust's records can develop specific policies, procedures and guidelines to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

1.5 This Policy contains a suite of procedures relating to the management of healthcare records and is highlighted in the schema below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Access to Health records procedure
- Managing adopted Childrens records
- Managing records of transgender individuals

2 SCOPE

2.1 All Trust staff including the Alliance, whether clinical or administrative, who create, receive and use records have records management responsibilities. This policy applies to all those Trust staff and relates to all clinical healthcare records held in any format by the Trust. These are:

Patient health records - a health record consists of information about the physical or mental health or condition of an individual, made by or on behalf of a health worker in connection with the care of that individual

Specialty managed health records – all health records in any format that are not part of the core patient record should be managed in accordance with these guidelines with separate records guidance produced by each department to be managed locally, these include but are not limited to:

- ED
- Alliance Hospital records
- Maternity
- Oncology
- Renal Transplant
- Eye casualty

2.2 Detail on the required retention periods for health records can be found in Appendix H.

2.3 The key components of healthcare records management which are governed by this policy are:

- record creation;
- record retrieval and location;
- record security and storage;
- record maintenance;
- tracking and transportation;
- retention, disposal and destruction
- Updating and redacting information in records

Where independent specialty areas develop additional local procedures then they must fully comply with the requirements of this policy and its supporting procedures.

3 DEFINITIONS

3.1 A ***Document*** is any piece of written information in any form, produced or received by an organisation or person. It can include databases, website, email messages, word and excel files, letters, and memos. Some of these documents will be ephemeral or of very short-term value and should never end up in a records management system (such as invitations to lunch).

3.2 A ***Healthcare Record*** is defined by the Data Protection Act 2018 as a record containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the ongoing care of the patient to whom it refers.

3.3 ***Personal data*** is defined as data relating to an individual that enables him/her to be identified either from that data alone or from that data in conjunction with other information in the data controller's possession. It therefore includes such items of information as an individual's name, address, age, race, religion, gender and physical, mental or sexual health.

3.4 The term ***Records Life Cycle*** describes the life of a record from its creation through the period of its 'active' use, then into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

3.5 ***Transitory records*** are records that have only temporary value. They are produced in the completion of routine actions, in the preparation of other records that supersede them and / or for convenience of reference. They are NOT official copies of records which need to be retained as evidence of an activity and they have no significant informational value after they have served their primary purpose.

4 ROLES AND RESPONSIBILITIES

4.1 **Executive Lead for Records**
The Executive Lead has overall responsibility for records management in the Trust. As Accountable officer he/she is responsible for the management of records within the Trust and for ensuring appropriate mechanisms are in place to support service delivery and continuity.
The UHL Executive Lead for Records is the **Chief Information Officer**

4.2 **Senior Information Risk Owner (SIRO)**
The SIRO is a nominated person (Executive or Senior Manager on the Board) who is familiar with information risk and the organisations response to risk. The SIRO takes ownership of the organisation's information risk policy and acts as an advocate for information risk on the Board who is also the Senior Information Risk Officer. The SIRO for the Trust is the **Chief Information Officer**.

4.3 **Caldicott Guardian**
The Trust's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner. At UHL the Caldicott Guardian is the **Medical Director.**

4.4 **Information Governance Steering Group**
The Information Governance Steering Group (IGSG) is responsible for ensuring that this policy is implemented and maintaining oversight of all records (healthcare and corporate) management compliance against national requirements e.g.

- Care Quality Commission requirements
- Data security and protection toolkit

4.5 **Head of Privacy (Information Governance Manager)**
The Head of Privacy & Information Risk has lead responsibility for Data Protection, Confidentiality and the Data security and protection Toolkit within the Trust. Ensuring staff have access to the up to date guidance on keeping personal information secure; ensuring that evidence is made available to support the attainment levels reported to Connecting

for Health; reviewing and evaluating IG arrangements and communicating changes in assessment/guidance across all functional areas; The Head of Privacy should be contacted in the event of IG queries or incidents.

4.6 **Healthcare Records General Manager**
The Healthcare Records General Manager is responsible for ensuring that the healthcare records Policy is implemented and is responsible for drawing up guidance for good records management practice, and developing a performance management framework.

4.7 **Head of Risk Assurance**
The Head of Risk Assurance is responsible for providing risk management leadership across the Trust including the development and implementation of the Trust's risk management strategy and risk management processes; development and maintenance of a Trust-wide risk register and coordination of the Trust's risk management activity including provision of risk management training, support and guidance.

4.8 **Managers within CMGs / Directorates**
The responsibility for local records management is devolved to the relevant directors, clinical management group managers, directorate managers and department managers. Heads of Departments, other units and business functions within the Trust have overall responsibility for the management of records generated by their activities, i.e. for ensuring that records controlled within their unit are managed in a way which meets the aims of the Trust's records management policies.

4.9 **All Staff**
All Trust staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and with any guidance subsequently produced.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 Policy Statement

When Trust staff manage a Healthcare Record then they are required to comply with the requirements of the Procedures and Requirements which appear as Appendices to this Policy.

5.2 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Senior Information Risk Owner will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The Access to Health Records Act 2018 (covers deceased patients);
- The General Data Protection Regulation 2018 (covers live patients);
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality; and
- The NHS Confidentiality Code of Practice.
- Records Management code of practice 2021
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

5.3 Associated documents - Retention and Disposal Schedules

5.3.1 It is a fundamental requirement that all of the Trust's records are retained for a minimum period of time for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's business functions.

5.3.2 The Trust has adopted the retention periods set out in the Department of Health Records Management: NHS Code of Practice 2021. This informs the content of Appendix H

5.4 The aims of our Healthcare Records Management System are to ensure that:

- **Healthcare records are available when needed** - from which the Trust is able to form a reconstruction of activities or events that have taken place;

- **Healthcare records can be accessed** - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;

- **Healthcare records can be interpreted** - the context of the record can be interpreted: who created or added to the record and when or how the record is related to other records;

- **Healthcare records can be trusted** – the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;

- **Healthcare records can be maintained through time** – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;

- **Healthcare records are secure** - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled, and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required.

- **Healthcare records are retained and disposed of appropriately** - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and

- **Healthcare records staff are trained** - so that all staff are made aware of their responsibilities for record-keeping and record management.

6 TRAINING

6.1 All UHL staff are required to undertake mandatory yearly Information Governance training through the UHL training system

Given the variety of healthcare records within the organisation, which can be, electronic or manual, identifying additional training needs and training provision is the responsibility of local healthcare records managers and electronic systems owners.

All managers must ensure that their staff receive the appropriate training for the healthcare records which they keep (e.g., pathology records, physio records etc) or the healthcare record systems which they operate (e.g., TrackIT - Medical records electronic tracking and requesting system).

7 MONITORING HEALTHCARE RECORDS MANAGEMENT COMPLIANCE

7.1 The Healthcare Records General Manager will establish a performance management framework, reported through the Information Governance Steering Group, through which healthcare records management compliance, and therefore this policy, will be monitored.

7.2 Specific monitoring criteria are detailed in each of the appendices procedures and appendix L of this policy.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 ASSOCIATED POLICIES AND PROCEDURES

There are a number of policies and procedures within the Trust that should be read in conjunction with this document for a complete understanding of how the Trust is organised and the strategies in place to fulfil its obligations. The key documents are listed below:

- **Data Protection and Confidentiality Policy A6/2003**
- **Information Governance Policy B4/2004**
- **Freedom of Information Policy A9/2004**
- **E-Mail and Internet Usage Policy A9/2003**
- **Information Security Policy A10/2003**

This guidance sets out a range of circumstances in which health professionals may receive, and respond to, requests for access to health records. It reflects the common enquiries received by the BMA.

- bma-access-to-health-records-nov-19.pdf

Appendix B - UHL Healthcare Records Creation Procedure

UHL Healthcare Records Creation Procedure

University Hospitals of Leicester NHS
NHS Trust

B1 Introduction

Healthcare record creation is primarily concerned with the development and implementation of an effective healthcare records management system to enable UHL to fulfil the requirements specified in the **Records management: NHS code of practice**.

This Procedure is one of a suite of policies and procedures relating to records management and information governance as shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

B2 Scope

This procedure applies to all UHL Trust staff that register patients on the Hospital Information Support System (HISS) / Patient Centre and/or create paper original, temporary or duplicate paper clinical healthcare records within UHL. It is to be noted that UHL is on an EPR journey and as such the systems and processes in use will change which will warrant an update to this guidance. This procedure also applies to the Alliance sites and associated records

B3 Definitions

The main systems used when creating electronic patient records within the Trust are set out below:

B3.1 Hospital Information Support System (HISS)

The University Hospitals of Leicester (UHL) patient administration system

B3.2 Patient Centre

A web based front end version of the above HISS system

B3.3 Nerve Centre

UHLs Electronic patient record (EPR) platform – also used to create and manage ED patient registrations and attendances

B3.4 CITO

UHL's system used for holding and managing scanned and uploaded patient clinical information documents including ED scanned records

B3.5 TrackIT

Medical Records electronic requesting and tracking system

B3.6 What is a Health Care Record?

A Health Care Record is information recorded by a healthcare professional about a person for the purpose of managing their health care and can include multiple formats including paper, digital or physical such as plaster moulds.

The term 'Health Care Record' therefore includes a variety of patient records which are held or filed within a department and are not necessarily filed into the core hospital record for the patient.

All information relating to an individual patient is recorded onto the UHL and Community wide Hospital Information Support System (HISS), thus creating a virtual single patient record. Normally a patient will be registered on the HISS / Patient Centre system prior to or at admission to hospital and the patient history is accumulated on the Patient Master Index (PMI). Details are progressively added during the course of the patient's attendance as an outpatient or inpatient.

The legacy of merging the 3 UHL sites has meant that a patient may have their treatment history split across more than one set of healthcare records, across multiple sites.

B4 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

B4.1 Medical Records Managers

Medical Records Managers are responsible for the core patient healthcare records and the management of the records libraries. They have an up to date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information.

B4.2 All NHS employees

Under the Public Records Act all NHS employees are responsible for any records they create or use in the course of their duties.

B4.3 Staff with a responsibility for creating records

Staff who have a responsibility e.g. ward clerks, clinic coordinators, clinical staff must ensure they access the appropriate training in relation to creating records as detailed below.

- HISS / Patient Centre training is available by contacting the IT training team.
- Training on Track IT can either be done within the clinical area by a team leader/manager or by contacting the medical records team on the relevant site who can then arrange access
- Any specific training for other systems should be arranged through the individual service management teams

B5 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958 and Local government Act 1972;
- The General Data Protection Act 2018
- Health and Social Care Act 2008;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

B6 Procedure Standards

B6.1 Creation of an electronic Record

B6.1.1 Prior to the merging of the hospital/community site systems during 2003/4, all new patients were either allocated an “R” number if they attended the Leicester Royal Infirmary a “G” number if they attended the Leicester General Hospital or an “F” number if they attended the Glenfield Hospital. Following the merger, new patients, when registered, are allocated a ‘U’ number, whenever they attend any of the 3 UHL sites.

B6.1.2 It is imperative that when registering a patient on the HISS / Patient Centre system that a thorough check is done to ensure the patient is not already registered, failure to do this could result in a patient being registered twice and Clinicians not having access to important previous medical history for a patient attendance.

B6.1.3 It is equally as important to ensure that if a HISS / Patient Centre registration is located that might be for the patient to be registered that further checks are done to ensure that it is the correct patient, if there is any doubt then it should be checked by someone else before proceeding, checks with the patient regarding old addresses etc should be made rather than just assuming it is the correct patient otherwise the wrong patient’s details could end up being changed and the wrong patient records being used.

B6.2 Registering a Patient on HISS / Patient Centre (what case note number should be used?)

A patient should only be registered with a new “U” number in the following circumstances:-

- When the patient has never attended any of the 3 UHL sites.
- When the patient has an R, G or F set of healthcare records at another site, but not at the one the patient is currently attending. The patient

healthcare records at the other UHL site should also be requested and merged.

- If the original R, G or F set of healthcare records has been destroyed or microfilmed.

A new “U” number should not be issued in the following circumstances:-

- When a patient is admitted or attending a site where they already have a hospital number in use e.g. R, G or F; new admissions and appointments should be made on the same hospital number. If the patient has a set of healthcare records which may contain relevant information to their treatment at another UHL site, they should also be requested.

- When a patient is attending a site, where they have no hospital number, but has a “U” number registered by another site, make the appointment using the existing “U” number and request the “U” set of healthcare records.

For further information on patient registration, please refer to the HISS / Patient Centre training manuals

Within UHL there are a number of specialities using separate IT systems to record patient details and also those specialities who create their own healthcare records. These records will either be submitted for filing within the core healthcare records as a record of patient history, or held within their own departmental library.

Some of these areas register patients on HISS / Patient Centre with their own departmental prefix instead of a U number, e.g. Orthodontics use the prefix D; Renal patients are registered with a UR number. The Alliance sites also hold their own records with associated prefixes such as HD for Hinckley Hospital, LB for Loughborough etc.

B6.3 Duplicate HISS / Patient Centre Registrations

Staff registering patients should ensure they have conducted a thorough search of the HISS / Patient Centre index before they create a new registration; otherwise an unnecessary duplicate is created, and this could adversely impact the patient.

If a duplicate registration on HISS / Patient Centre is discovered (i.e. 2 System S numbers) the ‘Merge request for duplicate registration form’ should be completed, this can be found by searching using the word ‘merge’ on Insite and choosing the UHL document from the results list. This form must be submitted to the Data Quality Team at the LRI who will merge the registrations

Data Quality monitors duplicate registrations and a user who creates 3 or more obvious duplicate registrations will have their HISS / Patient Centre account temporarily disabled. Clearly, if a user has their HISS / Patient Centre account disabled, it is likely that this will have a major impact on their role. For this reason, the account will only be disabled after the user has had a number of warnings, including voluntary enrolment on a retraining session. Training will be offered at short notice to enable the user to be back in action with minimal delay.

Further details on patient registration can be located in the relevant HISS and Patient Centre training guides.

B6.4 Creation of a paper clinical record (Medical Record/Case note)

B6.4.1 The core hospital healthcare records are paper-based documents and are stored in libraries located in the LRI, GH, and LGH or with the current offsite storage provider.

B6.4.2 New case note folders are purchased by the individual department via the Trust print rooms on each site. Lever arch files are **NOT** advocated due to issues related to identity, filing convention / structure and storage

B6.4.3 A patient's healthcare record should contain the same demographic information as the electronic HISS / Patient Centre record and all clinical and nursing notes relating to the patient's treatment. Examples of these include: test results, surgical procedures, allergies, complications, drugs prescribed and any adverse reactions. Demographic labels can be printed from the HISS / Patient Centre system and used on all documentation within the case note folder itself, these labels contain the patient name, address and date of birth details as well as the Case note number and the hospital 'S' number. HISS / Patient Centre labels should NOT be used on the front of a case note folder.

B6.4.4 TrackIT labels should be printed from the TrackIT system and two should be placed on the front of the case note folder. These labels have a document ID number on that enables the notes to be stored, located and tracked quickly and efficiently by the relevant staff.

B6.4.5 When filing paperwork within a paper record, the filing order to follow is printed on the inside of the case note folder (Refer to UHL Patient Records Maintenance Procedure and UHL Documentation Policy for Patients' Healthcare records – see links at the end of this document).

B6.4.6 Within UHL there are a number of specialities who create their own healthcare records. These records will either be filed within the core healthcare records as a record of patient history by the department that holds them or held within their own departmental libraries. Areas that hold their own paper records are:

Emergency Dept
Physiotherapy
Oncology
Maternity
Orthodontics & Restorative Dentistry
Breast Screening
Clinical Genetics
Occupational Therapy
Speech Therapy
Eye Casualty
Assisted Conception Unit
Occupational Health
Vascular Surveillance
Neurophysiology
Imaging

B6.4.7 Where independent specialty areas create and hold their own healthcare records they are required to develop additional local approved procedures detailing the processes for managing their healthcare records lifecycle.

B6.5 Creation of Temporary paper Healthcare records

A temporary set of healthcare records should only be created when a set of original healthcare records is not available on request (but they are NOT actually missing) i.e. when a patient is an inpatient and the original healthcare records are in transit from elsewhere.

Temporary healthcare records should only be a short term measure until the original healthcare records become available, at which point the temporary notes must be filed within the original healthcare records.

All documentation which forms a set of temporary notes should be placed in either a plastic wallet or envelope and labelled with a patient ID sticker. Temporary notes must **NOT be tracked** however should the temporary records move location i.e. to another ward with the patient, then the temporary healthcare records must be converted into a duplicate set of notes (see procedure below)

If the original healthcare records become permanently unavailable i.e. they are missing and not expected to be found, the temporary healthcare records must be converted into a duplicate set of notes (see procedure below)

Ward and Clinic clerical staff are responsible for amalgamating temporary sets of healthcare records with the originals when they are available, following the filing instructions on the inside of the case note folder.

Temporary healthcare records / envelopes must NOT be returned to file either inside the core set of healthcare records or on their own. All documentation must be securely fastened within the healthcare records under the relevant spine.

B6.6 Creation of Duplicate paper Healthcare records

A duplicate set of healthcare records must **only** be created when all avenues to locate the original set of healthcare records has been exhausted and in the following circumstances:-

B6.6.1 **Elective admission/clinic – made up before clinic attendance or admission**
Copies of appropriate letters and information must be obtained from the relevant clinic or secretary in order to recreate some of the medical history. A new case note folder should be created using the existing patient case note number and the duplicate volume created in TrackIT. A (TrackIT) label clearly denoting it is a 'D' volume should be printed and affixed to the case note. The duplicate should be tracked to the relevant location.

B6.6.2 **Emergency admission – made up after all searches for the original notes have been exhausted**
Contents of any temporary envelopes etc should be transferred to a new case note folder. A new case note folder should be created using the existing patient case note number and the duplicate volume created in TrackIT. A (TrackIT) label clearly denoting it is a 'D' volume should be printed and affixed to the case note. The duplicate should be tracked to the relevant location.

B6.7 Merging of Duplicate paper Healthcare records

Where duplicate sets of healthcare records exist for a patient both sets must be obtained and merged both electronically in TrackIT and manually and filed at the last hospital the patient attended. (Refer to merging section of TrackIT Document Management guide - follow link in section 8)

Duplicate notes returned to Medical Records with the original healthcare records will automatically be returned to the last user for merging.

It is the responsibility of the administrative staff (Ward clerks, Clinic preparation, Clinic co-ordinators etc) in each department for merging the healthcare records.

B7 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in appendix I.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

B8 Supplementary guidance

- Data Protection and Confidentiality Policy A6/2003
- Information Governance Policy B4/2004
- Freedom of Information Policy A9/2004
- E-mail and internet Usage Policy A9/2003
- Information Security Policy A10/2003

UHL Locating Healthcare Records and Requesting Procedure

University Hospitals of Leicester NHS
NHS Trust

C1 Introduction

This Procedure is one of a suite of policies and procedures relating to records management and information governance and is shown below:.

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

This procedure relates to University Hospitals of Leicester's (UHL) core healthcare records only. A number of independent specialty healthcare records are created and used within the trust; however, the processes for requesting these notes are described in separate, local records approved documentation.

C2 Scope

This procedure applies to all UHL Trust staff who request and / or require UHL core healthcare records. This includes Ward Clerks, Clinic Coordinators, Secretaries and Admin/support staff and has been produced to inform staff of their responsibilities in the locating and requesting of patients core healthcare records.

C3 Definitions

C3.1 UHL Core Healthcare Records

The Healthcare Records used for recording patient care activity delivered by UHL

C3.2 TrackIT

The local name given to the Trust's electronic core case note requesting and tracking system implemented in June 2009

C3.3 Hospital Information Support System (HISS)

UHL's patient administration system

C3.4 Nerve Centre

UHLs Electronic patient record (EPR) platform – also used to create and manage ED patient registrations and attendances

C3.5 CITO

UHL's system used for holding and managing scanned and uploaded patient clinical information documents including ED scanned records

C3.4 CITO – The Electronic Document Records Management (EDRM) system

Electronic notes is the system used to view healthcare records that have been SCANNED

C4 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

C4.1 Medical Records

Medical Records staff are trained in the use of TrackIT within 1 week upon commencement within the department. There is an induction programme for all medical records staff that covers training in the use of the libraries, mis-file procedures, and locating notes within departments and also includes HISS/Patient Centre training.

All medical records staff will shadow trained members of staff until they (and the mentor) feel they are able to fulfil their duties alone. Management then monitor staff adherence to previously set department standards to ensure a high quality service is provided.

C4.2 CMG Areas

All responsible staff must ensure they have been trained supported by the TrackIT user guides and adhere to the standards set out in this procedure.

For areas that locate the healthcare records themselves, staff should be fully trained to the same standards as Medical Records Staff and also abide by the same policies and procedures. Departments can seek advice on any aspects of these policies and procedures from the Medical Records Managements teams at any of the UHL sites.

C5 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The Data Protection Act 1998;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

C6 Procedure Standards

C6.1 Core Healthcare Records

All UHL core healthcare records have a unique case note number (sometimes referred to as a document id). Since 2004 the core healthcare records of new patients have been given a unique case note number prefixed with the letter U (for Unified). Patients who were known to UHL prior to 2004 may have core healthcare records with the prefix: R (for LRI), G (for LGH) and F (for GH).

Many patients have multiple healthcare records, for example a U set, a G set and an F set. In addition a patient can have multiple volumes of healthcare records, for example U volumes 1, 2 & 3. A patient may also have duplicate core healthcare record, for example when a patient has been admitted and the core healthcare records are in transit, a duplicate set of core healthcare records will be created as a temporary repository for the patient's clinical information. All core UHL healthcare records therefore have a prefix to indicate whether it is a volume or a duplicate.

Each physical set of healthcare records is labelled with a unique case note number, which enables the notes to be independently tracked. For example:

U1234567-V1
F98414-V1
F98414-V2
G100897-V1
G100897- D1

This is why the case note number is sometimes referred to as the document id

The service provided by UHL's Medical Records Service varies at each UHL site:

C6.2 Requesting UHL core healthcare records

There are several factors which determine how and when a set of UHL core healthcare records should be requested from medical records;

Departments must request healthcare records from medical records using TrackIT. Requests for healthcare records required for inpatient and outpatient attendances (which have been booked on HISS/Patient Centre) are automatically generated in TrackIT so do not need requesting manually.

The only exception to this is if healthcare records are required by a GH department and the notes are not within the medical records library at GH, GH CMG department staff have to locate the notes themselves.

The type of request: automated requests are generated within the TrackIT system for inpatient and outpatient attendance (booked through HISS / Patient Centre).

Where the notes are currently located: if the healthcare records are located in off site storage or in non UHL hospitals specific processes apply – see sections below.

C6.3 Healthcare records stored offsite

Over 1 million sets of UHL core healthcare records are stored offsite. Healthcare records sent to off site storage are tracked to the storage provider in TrackIT. If a department requires a set of healthcare records which are being stored off site they must request them from medical records using TrackIT (unless the healthcare records are required for an inpatient or outpatient attendance which has been booked on HISS, as these are automatically generated.

Requests for healthcare records being stored in off site storage are dealt with by a centralised team based at the LRI who will liaise with the offsite storage company and arrange for delivery to the appropriate site.

Each site has at least one daily delivery from the offsite storage company and most requests will be delivered to medical records within 24 - 48 hours of request.

For urgent requests required in less than 24 hours, please contact the Medical Records Management team at the LRI – *contact details can be found on INSITE under Working Life, Managing Information, Medical Records, Contact Us.*

C6.4 Healthcare records SCANNED and available via CITO

Paediatric records under the age of 15 during 2015 to 2016 were scanned and made available via the EDRM system which is called CITO. These records are identified as 'Scanned' on the Track IT system. Other records are now stored within CITO including scanned ED records, Clinical genetics records and many other documents. These are available to view for anyone with the appropriate access

C6.5 Healthcare records held at non UHL hospitals or healthcare providers

UHL healthcare records required for clinical activity and situated at a community hospital are requested by medical records from each community hospital using TrackIT generated lists. This includes outpatient activity, inpatients and TCI's. All ad-hoc activity (notes required for Doctors to view, filing etc) has to be requested by phone or fax directly from the community hospital by the person requiring the notes.

Alliance or other community records have to be requested by phone or fax directly from the community hospital by the person requiring the notes.

C6.5 Microfilmed healthcare records

Up until 2005 Glenfield Hospital healthcare records over 4 years old were microfilmed. Microfilmed healthcare records are stored at Glenfield Hospital:-

- In line with the trust's *health records retention and destruction guidelines*, patient information that is over 8 years old and has been microfilmed **will not** be recreated. This applies to both adult and children's health records. This information can be viewed by the requestor in microfilm format, by arranging an appointment via the Glenfield Medical Records Management Team on x13892.

C6.6 Notes required for Research

If UHL core healthcare records are required for research purposes, the requestor must first contact the Research & Development Office to obtain Trust approval which will confirm Ethics, MHRA and other regulatory organisation approvals. If

approval is granted, the requestor will be given an approval number which must be entered when making a case note request in TrackIT.

C6.7 Notes required for Audit/Service Evaluation or Mortality & Morbidity meetings

C6.7.1 Audit

If UHL core healthcare records are required for an Audit contact the CASE (Clinical Audit, Standards and Effectiveness) Team to confirm this has been registered either as a trust or CMG priority audit. If registered, the requestor will be given a registration number which must be entered when making a case note request in TrackIT.

C6.7.2 Service Evaluation

If UHL core healthcare records are required for a service evaluation project contact the CASE (Clinical Audit, Standards and Effectiveness) Team to confirm approval. If registered, the requestor will be given a registration number which must be entered when making a case note request in TrackIT.

C6.7.3 Mortality and Morbidity (M&M)

If UHL core healthcare records are required for mortality and morbidity meetings the specialty head of service or M&M medical lead should be contacted to confirm appropriateness of request and volume of notes required.

C6.8 Contacting medical records, operating hours and library access

C6.8.1 Medical Records Centralised Helpdesk

Medical Records operates a centralised helpdesk and can be contacted via extension 13499 – between the hours of 8:30am and 4:30pm Monday to Friday.

C6.8.2 Operating hours and library access

Site	Opening Hours	Management Team	Out of hours access	Library access
LRI	8:00am - 4:30pm Monday - Friday	X17621	via Duty Managers who will liaise with security to gain access (Emergency / Critical out of hours admissions)	Key pad and swipe cards.
LGH	8:30am - 4:30pm Monday - Friday	X14271 x14268	Via the Portering Services Department.	Key fob and coded key pads.
GH	8:00am - 4:30pm Monday - Friday	X13851 x13892	Via the 'Live Bed State' team who can be contacted via switchboard.	Key pad and swipe cards.

C6.9 Location of the Medical records offices

The Medical Records offices are located:-

C6.9.1 LRI Medical Records Office Location

The management office is located in the Balmoral building Level 0, just past the Balmoral lift lobby. There are also 4 Medical Records libraries, 1 in the Hearing Services building basement, 1 on Level 2 of the MHU building on Havelock Street, 1 in the basement of the Victoria building and 1 small area within the basement of the Jarvis building.

C6.9.2 GH Medical Records Office Location

GH medical records is located in the Snoezlen Building which is situated behind Mansion House

C6.9.3 LGH Medical Records Office Location

The management office is located off the main corridor, from the main reception corridor turn left then left again after the WRVS shop and they are on the right hand side towards the end of the corridor.

C7 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix L.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

UHL Healthcare Records Maintenance Procedure

University Hospitals of Leicester NHS
NHS Trust

D1 Introduction

This procedure is required to ensure that a records maintenance regime is in place across UHL which will sustain or preserve records for as long as they are required and to enable UHL to undertake the required range of activities specified in the Records Management Policy, which enables:

- The Patient to receive continuing care,
- Healthcare teams to communicate effectively,
- Other doctors or professional members of staff to assume the care of the patient at any time, the Patient to be identified without risk or error,
- Facilitates the collection of data for research, education and audit and can be used in legal proceedings.

This Procedure is one of a suite of policies and procedures relating to records management and information governance and is shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

D2 Scope

This procedure applies to all UHL Trust staff who handle core healthcare records and sets out the responsibilities for maintaining paper clinical patient records (Healthcare Records) within UHL e.g. medical staff, nursing staff, ward clerks, clinic coordinators, secretaries etc.

D3 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

D3.1 Medical Records Managers

Medical Records Managers are responsible for the core patient healthcare records and the management of the records libraries. They have an up to date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information.

D3.2 All NHS employees

Under the Public Records Act all NHS employees are responsible for any records they create or use in the course of their duties.

D3.3 Staff with a responsibility for maintaining records

Staff who have a responsibility e.g. medical staff, nursing staff, ward clerks, clinic coordinators, clinical staff, secretaries, admin and support staff must ensure they adhere to the standards set out in this procedure.

D4 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The General Data Protection Regulation;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

D5 Procedure Standards

D5.1 Record Filing and Maintenance Standards

All UHL Trust staff are required to adhere to the following requirements: -

- Accurately record the location of the core healthcare records on the hospital electronic tracking system TrackIT.
- File **ALL** documentation in chronological order, adhering to the Filing Order (see inside back cover of case note folder).
- File any loose papers (discharge/clinic letters, results) received post patient discharge.
- Check that no duplicate documentation is filed.
- Maintain the core healthcare records so they are always in a good state of repair and are tidy.
- Store and move the core healthcare records in a secure manner to safeguard patient confidentiality.
- If healthcare records are lost create a duplicate healthcare record in the TrackIT system and track accordingly.
- Incorporate temporary or duplicate folders into original case-notes when located and amend the TrackIT system, as appropriate.
- Indicate any additional volumes on the front cover.

D5.2 Torn or damaged folders

These need to be repaired or replaced by specialty and department admin staff including clinic co-ordinators and ward clerks when received into their department in a poor condition.

D5.3 Multiple volumes

Some patient healthcare record folders eventually become unmanageable due to the amount of documents which are used when the patient is attending as an outpatient or inpatient. Due to the bulk, it is necessary to divide the notes into manageable volumes and as a guide 10cm thickness denotes the need for a further volume.

When a second or consecutive folder is created the volume number should be clearly marked on the front cover of the folder, e.g. Volume 1 of 3, Volume 2 of 3, Volume 3 of 3 etc. All additional volumes of patient notes that are created should be created in TrackIT and Document ID labels denoting the volume number should be printed and placed over the existing ID labels on the folder, e.g. U1111111-V1, U1111111-V2 etc.

The records must be securely banded together and must remain together as a complete set when transferred from one area to another. In some circumstances volumes can be archived and stored separately to current volumes if required. TrackIT enables volumes to be identified, tracked and requested independent of one another, contact Medical Records for advice if required.

D5.4 Ordering Healthcare Record (Case note) Folders

ordering of new case note folders is done via the online internal stationery ordering system via the Trust Print Rooms. It is essential orders are placed before there is any risk of running out.

The cost of the folders is charged to your specialty

D5.5 Staples

Staples must not be used when attaching items to healthcare records folders as it damages the folders, breaks the laminate on the outside of the folders (Used for Infection prevention purposes) and also is a Health & Safety risk to staff.

D5.6 Patient ID labels

A patient's core healthcare records should have the appropriate bar-coded identification labels printed from the TrackIT system denoting the document ID and the volume e.g. patient U3434343 should have a document ID label U3434343-V1. The document ID label must be securely attached to the outside of the patient healthcare records and be clearly legible. These must be replaced should the patient details become out of date, damaged or illegible.

HISS patient ID labels must NOT be used on the front of case note folders but can be used within the folder on documentation as required.

D5.7 Filing / Loose documentation

The CMG departments are responsible for the filing of all documentation within the case note folders. In particular when patients are discharged the ward clerk should ensure that all documentation from the ward is securely filed in the case note prior to it leaving the ward.

The relevant clinic co-ordinators ward clerks or departments must make every effort to secure reports in the original healthcare records. Any papers e.g. discharge/clinic letters, results, received post discharge must be filed within the healthcare records and NOT sent to Medical Records in a filing envelope as medical records **do not** provide a general filing service.

D5.8 Case note filing order

FRONT OF SPINE

1. ID LABELS (attached to spine)
2. PATIENT ID FRONT SHEET
3. ALERT SHEET
4. CLINICAL NOTES

FRONT OF BACK SPINE

1. NURSING NOTES
2. TEMPERATURE CHARTS
3. FLUID BALANCE CHARTS
4. MISCELLANEOUS CHARTS
5. OPERATION CONSENT FORMS
6. DRUG SHEETS
7. ANAESTHETIC SHEETS

REVERSE OF FRONT SPINE

1. RED HAEMATOLOGY REPORTS
2. GREEN CHEM PATHOLOGY FORMS
3. BLUE MICROBIOLOGY REPORTS
4. X-RAY AND RADIOISOTOPE SHEETS
5. MISCELLANEOUS REPORTS
6. HISTOPATHOLOGY REPORTS
7. BONE MARROW REPORTS
8. ECG REPORTS
9. EEG REPORTS
10. PHOTOGRAPHS AND SLIDES

REVERSE OF BACK SPINE

1. CORRESPONDENCE
(filed in DATE order)

Loose reports will not be accepted by Medical Records.

D6 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix I.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

Appendix E - UHL Healthcare Records Security and Storage Procedure

UHL Healthcare Records Security and Storage Procedure

University Hospitals of Leicester NHS
NHS Trust

E1 Introduction

This Procedure is one of a suite of policies and procedures relating to records management and information governance and is shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

E2 Scope

This procedure applies to all UHL Trust staff who store (including temporarily in offices etc) and handle healthcare records and has been produced to inform staff of their responsibilities relating to maintaining the security and confidentiality of healthcare records and for storing paper clinical patient records (Healthcare Records) within UHL.

Each member of staff is responsible for the safety and security of any healthcare records that they handle, transport or store.

E3 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

E3.1 Medical Records Managers

Medical Records Managers are responsible for the core patient healthcare records and the management of the records libraries. They have an up to date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information.

E3.2 All UHL Staff

All staff have a responsibility to ensure the safe and secure storage of patient healthcare records e.g. ward clerks, clinic coordinators, clinical staff, secretaries, admin and support staff must ensure they adhere to the standards set out in this procedure.

E4 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The General Data Protection Regulation;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

E5 Procedure Standards

E5.1 Security of healthcare records

Healthcare records should not be left in unlocked offices, cupboards etc. Particularly, holders of healthcare records have a duty to ensure that all notes are tracked out from their location whenever they are moved e.g. back to Medical Records Libraries.

It is imperative that healthcare records are not left unattended where they could be seen by members of the public i.e. outside a toilet, left outside the RVS shop. When transporting healthcare records please ensure there are no patient details visible i.e. always transport notes in bags/boxes etc or if transporting in open trolleys ensure the notes are turned over so no patient identifying information is visible. See the Patient Records Transportation Procedure for further information (link provided at the end of this document)

E5.2 Healthcare records stored outside of the Medical Records Libraries

Healthcare records stored in offices and wards etc should be kept in an organised and orderly manner so they can be easily retrieved.
Healthcare records held in departmental areas must be made available at all times to Medical Records staff. All areas should be locked when not in use and healthcare records must be securely held in these areas in lockable cupboards or cabinets. Keys or codes to these areas must be made available to Medical Records staff out of normal working hours to aid the speedy retrieval of healthcare records required for urgent need.

E5.2.1 Withholding Healthcare records

Healthcare records are not the property of individual Healthcare Professionals, nor the patient or department temporarily holding them.

The practice of withholding healthcare records is unacceptable within UHL. However, there may be circumstances where a set of healthcare records may already have booked to a particular clinic on say the 2nd of the month at one site, but they are also required for a clinic on the 1st of the month an another site. In these circumstances, the healthcare records must be released and communication with the appropriate person to ensure that every effort is made to return them on time for the next clinic.
If you have concerns regarding case note being taken from you then contact a member of the Medical Records Management team for advice.

E5.2.2 Removing Healthcare records without the present keeper's knowledge

If a set of healthcare records needs to be taken from their last booked location without the keeper's knowledge e.g. taken from a secretaries office whilst s/he is not there, then details of what has been taken, for what reason and by whom it was taken should always be left.

Any member of staff taking the healthcare records must track them to the intended destination on TrackIT.

E5.3 Storage of healthcare records in the Medical Records Library areas

UHL use two main systems to file healthcare records.

- Numeric (in use at LGH certain areas of the library) and
- Terminal digit (in use at GH, cellar areas of LGH and the main libraries at the LRI)

E5.3.1 Numeric Filing:

As the name implies the records are filed in straight numerical sequence.

This system is logical, easily understood and requires minimal staff training. Healthcare records are filed in ascending order and it is of particular benefit in situations where non medical records staff need to locate records from the filing system, outside of office hours.

With this system all new records are created at the end of the filing range. This system is problematic, in that all the growth is at one end of the system. When culling and destruction occurs, all records have to be shifted back to accommodate new patients.

As the growth is always at the end of the range it makes splitting the areas for individual filers very difficult as there is no way of knowing which areas each day will be busier than others.

E5.3.2 Terminal Digit Filing:

Terminal digit filing allows the last 2 or 3 digits of the case note number sequence to be used. For example 314573 would be filed under section 573 and within this section the notes are then filed numerically.

Terminal digit filing requires more staff training than straight numerical filing and the system may present problems when medical records does not provide 24 hour coverage and inexperienced members of staff are required to locate case note 'out of hours'.

Libraries where terminal digit is used are split into 1000 sections and are labelled 000 through to 999. For every patient registered onto the HISS system there will be one number per filing range. This means that for filing purposes the filing range can be split equally between filing staff as no number should be busier than another. This means that quality control measures can be put into place and staff will be responsible for a particular area of a library

It is easier to weed through each filing section and extract notes identified for destruction rather than shift back all the records as you would do with a numeric system.

UHL currently have the following 8 case note library locations across all 3 sites:-

LRI (closed library)
Materials Handling Unit (RMHU) – terminal digit
Hearing Services Basement (RLFILE) – terminal digit
Jarvis Basement (RLFA) - terminal digit
Victoria Basement (ROC3) – terminal digit

GH (closed library)
Snoezelen library (FLARGE, FMR) – both terminal digit

LGH (closed library)
Upstairs – Numeric (BIGLOC, LARLOC, GMR)
Cellar – Numeric & Terminal digit (GMR, GCELL3, GCELL4)

E5.4 Returning Healthcare records to the Medical Records libraries for filing and storage

When returning healthcare records to the Medical Records libraries they should be tracked on the TrackIT system to the following borrower/tracking codes:

LRI RRTL (Royal Return to Library)

GH FRTL (Glenfield Return to Library)

LGH GRTL (General Return to Library)

When Medical Records receive the notes they are sorted and re-tracked accordingly to the appropriate library borrower code

E5.5 Missing Case note escalation process

Medical Records staff have an internal process that they follow if they cannot locate a set of healthcare records. When notes cannot be found in time for a request, the request will be marked as ‘cancelled as missing’ in the TrackIT system. It is individual CMG department areas responsibility to monitor requests in TrackIT; you will not be informed independently of any cancellation of requests.

Reports are available from the TrackIT system that shows the number of healthcare records that Medical Records did not find in time for the request; the average monthly percentage for this is 1.5% unavailability

E5.5.1 Mis-file procedure

When a set of healthcare records is not found within the libraries, it may have been mis-filed. The mis-file procedure is dependent upon the method of filing used e.g. numeric or terminal digit filing.

Procedure for suspected mis-file under the **Numerical** filing system using number **314**763 as an example:

1) Search through all folders within the pigeon hole where the notes should have been filed

2) Transpose the first digit i.e. look at **0**14763 through to **9**14763

3) Transpose the second digit i.e. look at 3**0**4763 through to 3**9**4763

4) Transpose the third digit i.e. look at 31**0**763 through to 31**9**763 (although some of these options may have fallen into the pigeon hole as indicated in option 1)

5) Working outward from the pigeon hole where the notes should be filed check each pigeon hole completely for the entire 314 section, including the pigeon hole above and below even if these are outside of the 314 section

Terminal digit filing is where the last 2 or 3 digits of the number sequence are used. For example 314763 would be filed under section 763, within the section the notes are then filed numerically.

Procedure for suspected mis-file under the **Terminal Digit** filing system using number 314**763** as an example.

1) Search through all folders within the pigeon hole where the notes should be

2) Transpose the last digit i.e. 31476**0** through to 31476**9**

3) Transpose the second last digit i.e. look at 3147**0**3 through to 3147**9**3

4) Transpose the third last digit i.e. look at 314**0**63 through to 314**9**63

5) Working outward from the pigeon hole where the notes should be filed check each pigeon hole completely for the entire 763 section, including the pigeon hole above and below even if these are outside of the 763 section

6) Because it is common for various numbers to be printed on case note labels it is always worth checking the last 3 digits of the patient's S (HISS System number) and the last 3 digits of the NHS number.

E5.6 Location of the Medical Records Offices

The Medical Records offices are located:-

E5.6.1 LRI Medical Records Office Location

The management office is located in the Balmoral building Level 0, just past the Balmoral lift lobby. There are also 3 Medical Records libraries, 1 in the Hearing Services building basement, 1 on Level 2 of the MHU building on Havelock Street and 1 in the old Oliver ward of the Victoria building.

E5.6.2 GH Medical Records Office Location

The management office is located in the Snoezelen building which is located behind mansion house on the GH site

E5.6.3 LGH Medical Records Office Location

The management office is located off the main corridor, from the main reception corridor turn left then left again after the WRVS shop and they are on the right hand side towards the end of the corridor.

E5.7 Confidentiality of Patients' Health Records

A patient's health records should not be handed over to anyone unless the identity of that person is known and you are sure they are authorised to have access to such information. If in doubt check Trust identification badge, etc.

Healthcare records should never be left unattended in public areas. If a person is seen looking at a patient's records, check their identity and ensure they have the authorised access to health records. Rooms in which health records are stored should be locked whenever they are left unattended.

It may be necessary during the course of your professional duties to read part of the contents of the health record outside of the Trust premises, but this should only be as much as is absolutely necessary in the efficient performance of your duties.

When health records are transferred between departments they should be sent in the Trust agreed envelope/container:

They should only be carried by hospital personnel. The tracking of the change of location must be recorded on TrackIT.

When information is required by other healthcare providers outside of the Leicestershire district, a copy of the notes only must be sent. Originals should be retained on Trust premises, see the UHL Patient Records transportation Procedure for further information.

Ordinarily Healthcare records must not be taken home and appropriate arrangements need to be made to collect / drop off records at the beginning / end of a working shift. Under extraordinary circumstances where there is a need then managerial authority **must** be sought and a risk assessment completed with appropriate security measures adopted.

Should there be an absolute need to send the originals to any other organisation outside of the UHL, our Community hospital partners' and other healthcare providers within the Leicester and Leicestershire district then managerial authority **must** be sought and a risk assessment completed.

E6 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix I.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

Appendix F - UHL Healthcare Records Tracking Procedure

UHL Healthcare Records Tracking Procedure

University Hospitals of Leicester NHS
NHS Trust

F1 Introduction

One of the main factors contributing to misplaced records is that record movements are not recorded. The success of a records tracking system depends on the people using it and all staff should be aware of its importance and be fully acquainted with its operation.

This Procedure is one of a suite of policies and procedures relating to records management and information governance and is shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

F2 Scope

This procedure applies to all UHL Trust staff who handle healthcare records including Secretaries, Ward Clerks, Clinic Coordinators, Admin / Support Staff and has been produced to inform staff of their responsibilities when tracking paper clinical records (Healthcare Records) within UHL.

F3 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

F3.1 Medical Records Manager

The Medical Records Manager will manage the Medical Records Department and will be responsible for enforcing the Medical Records Policy.

F3.2 Medical Records Staff

The Medical Records staff will track all core healthcare records to the requesting borrower ensuring the corresponding TrackIT request label is affixed to the front of the healthcare records. The Medical Records staff will track all returned core healthcare records to the relevant Medical Records storage borrower code.

F3.3 CMG / Directorate Department Managers

It is the responsibility of department managers to ensure:

- All staff in their remit are aware of and adhere to the Records Management policy and Healthcare records procedures.
- Patients Healthcare Records are appropriately managed whilst in the department in accordance with the Healthcare records procedures. Including tracking, maintenance, filing of information and storage.
- Remedial action is taken to resolve any non-compliance issues.

F3.4 All UHL Staff

- ✓ Patient Identifiable Details (PID) are **not** on display (down turned on desks / in trolleys)
- ✓ Patient records are tracked (manually/electronically) when passed from one place/person to another
- ✓ Patient records are transported safely and securely
- ✓ Patient records are returned to secure storage areas

All staff Including Secretaries, Ward Clerks, Clinic Coordinators, Admin / Support Staff are responsible for adhering to the requirements within this procedure.

F4 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The General Data Protection Regulation;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

F5 Procedure Standards

F5.1 Tracking

All core healthcare records must be tracked using the TrackIT system.

The TrackIT system provides:

- The ability to create & independently track healthcare records including additional volumes & duplicate healthcare records.
- Automatic requesting of UHL healthcare records for HISS/Patient Centre clinics & wards.
- The ability to track the progress of your request/s.
- Provides performance & activity monitoring
- Provides accurate monitoring of the standard of service

It is the responsibility of the person sending the healthcare records to track them to the intended location (borrower code) on each occasion.

The receiver may also track healthcare records to their own location, which provides a check that the healthcare records have been received.

Accurate tracking of records within UHL's electronic tracking system (TrackIT) is essential to:-

- Enable the record to be located quickly and efficiently to allow for informed clinical decisions to be made ensuring the best possible patient care.
- Control the movement and location of records to ensure that they can be easily retrieved at any time and any outstanding issues can be dealt with.
- Monitor the usage for the maintenance of systems and security.
- Maintain an auditable trail of records transactions, such as registration, access and disposal

F5.2 Borrower Codes

All locations where healthcare records are requested to e.g. secretaries office, wards etc, should have a TrackIT 'Borrower' code assigned to them. The Medical Records Management Team will maintain the locations / borrower codes within the TrackIT system to ensure that locations are up to date and enable users to track records to the correct location. Should a location not have a borrower code assigned to it you must contact a member of the Medical Records Management Team who will create a borrower code for the location.

It is a mandatory requirement for all UHL staff handling healthcare records to have access to the electronic case note tracking system (TrackIT) by completing TrackIT training. Contact Medical records management for training. There are also user guides available on SharePoint to support users further.

The consequences of incorrect or not tracking healthcare records are potentially serious for both the patient and anyone handling healthcare records e.g. incorrect diagnosis, patient sent home!

F6 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix L.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

Appendix G - UHL Healthcare Records Transportation Procedure

UHL Healthcare Records Transportation Procedure	University Hospitals of Leicester NHS NHS Trust

G1 Introduction

Patient healthcare records are moved on a very regular basis to numerous destinations including between departments on the same UHL site, between all UHL sites, to other NHS Hospitals, private hospitals and out of district healthcare providers. It is important that patient's confidentiality, privacy and dignity are protected at all times during the transportation of their healthcare records.

This Procedure is one of a suite of policies and procedures relating to records management and information governance and are shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

G2 Scope

This procedure applies to all UHL Trust staff that move and transport healthcare records and has been produced to inform staff of their responsibilities with regard to the transportation of paper clinical records (Healthcare Records).

G3 Roles and Responsibilities

All members of staff have a responsibility to ensure that confidentiality, privacy and dignity are protected at all times during the handling of healthcare records

All staff regardless of seniority must be aware of their responsibilities pertaining to the healthcare records and aforementioned policies / procedures and ensure they are adhered to.

G3.1 Medical Records Manager

The Medical Records Manager will manage the Medical Records Department and will be responsible for enforcing the Healthcare Records Procedures.

G3.2 CMG / Directorate Department Managers

It is the responsibility of department managers to ensure:

- All staff in their remit are aware of and adhere to the Trust Records Management Policy and Healthcare records procedures.
- Patients Healthcare Records are appropriately managed whilst in the department in accordance with the Trust Records Management Policy. Including tracking, maintenance, filing of information and storage.
- Remedial action is taken to resolve any non-compliance issues.

G3.3 All UHL Staff

Must ensure:

- ✓ Patient Identifiable Details (PID) are **not** on display (down turned on desks / in trolleys)
- ✓ Patient records are tracked (manually/electronically) when passed from one place/person to another
- ✓ Patient records are transported safely and securely
- ✓ Patient records are returned to secure storage areas

All staff Including Secretaries, Ward Clerks, Clinic Coordinators, Admin / Support Staff are responsible for adhering to the requirements within this procedure.

G4 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The General Data Protection Regulation;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

G5 Procedure Standards

G5.1 Transportation of Patient Healthcare records to out of district healthcare providers

Healthcare records should NOT be sent directly via the internal mail system, but sent via Medical Records during normal working hours, as this is the only department that may send patient healthcare records outside of the Leicestershire Hospitals.

If a patient is transferred to an out of district healthcare provider such as Queens Medical Centre etc then the patient healthcare records should be sent with the patient and tracked accordingly on the TrackIT system. If you cannot find a borrower code for where you are sending the patient please contact the medical records manager at your respective site as soon as possible who will create one for you.

G5.2 Transportation of Patient Healthcare records to Community Hospitals and other healthcare providers within Leicester and Leicestershire district

There are daily deliveries to most community hospitals within Leicestershire from the post rooms on each UHL site. If sending healthcare records to these areas ensure that they are wrapped in bags that are securely sealed and labelled with enough information to get to the correct destination. Ensure the healthcare records have been tracked on the TrackIT system.

If you need to get notes to a healthcare provider that does not have a delivery from the post rooms do NOT post the healthcare records using the external Royal Mail

system. Take these notes to the medical records tracking team on your respective site who will send the notes recorded or special delivery as applicable.

Ordinarily Healthcare records must not be taken home and appropriate arrangements need to be made to collect / drop off records at the beginning / end of a working shift. Under extraordinary circumstances where there is a need then managerial authority **must** be sought and a risk assessment completed with appropriate security measures adopted.

Should there be an absolute need to send the originals to any other organisation outside of the UHL, our Community hospital partners' and other healthcare providers within the Leicester and Leicestershire district then managerial authority **must** be sought and a risk assessment completed.

G5.3 Transportation of Urgently required Healthcare records between UHL Sites

Medical Records provides a service to transport 'Urgent' and 'Next Day' healthcare records. There are a number of urgent deliveries per day to each site, which are in addition to the existing routine deliveries currently provided. Any queries contact the medical records management team on your site.

G5.4 Transportation of notes by UHL staff between departments on the same site

Notes are often transported in open or uncovered trolleys; as such the following guidance should be followed:

- Notes should be transported with a member of staff who is aware of the Trust policies and procedures (as detailed below) regarding confidentiality
- Covers are available for trolleys, however, these are impractical for staff that need to regularly go into the trolleys either to add notes or take notes out. The covers may be useful when notes are merely being transported by staff from one location to another.
- Where covers are not practical it is advised that **all** notes MUST be put into the trolleys face down so that no details are visible to onlookers e.g. when in a lift, walking in corridors with patients/relatives coming past etc.

G5.5 Transportation of notes by UHL staff cross sites or to other external places

Notes are often transported in unsuitable packaging; as such the following guidance should be followed:

- Notes should be transported with a member of staff who is aware of the Trust policies and procedures (as detailed below) regarding confidentiality
- All notes being transported off site should be in sealed bags or envelopes, NEVER package healthcare records in black plastic bin liners as these can (and have in the past) been mistaken for rubbish
- If the trolley the notes are being transported in is covered then the notes within do not need to be in bags or envelopes
- Although the ideal situation is to have trolleys that are lockable, as long as they are never left unattended this is sufficient

G5.6 Transportation of notes by patients, relatives or carers between departments and/or UHL sites

There is a possibility of a breach of patient confidentiality due to a patient, relative or carer viewing healthcare records. Documentation could be removed or added to, potentially causing complaint and/or litigation issues, notes cannot also be guaranteed to arrive at their destination.

- All CMG's are advised that notes should **not** ordinarily be transported by a patient, relative or carer
- If no other alternative is available then notes should be placed in an envelope, sealed securely and a signature of the person sealing the envelope to be written across the seal and sellotape across the seal.
- Advice should be given to the patient, relative or carer that they are not entitled to view the notes without applying to the Access to Health Records Department
- The person receiving the notes should check the seal and if the seal looks to have been tampered with, they should inform the Medical Records Manager on the site. If the Medical Records Manager agrees that a potential breach of confidentiality could have occurred they should record this as an incident on Datix. These incidents will be monitored by the Medical Records Service Manager in conjunction with the Trust Information Governance Manager
- If notes do not arrive at destination, inform the Medical Records Manager as per the instructions above
- Alternatives include use of Medical Records service for cross site transfers during working hours Monday to Friday

G6 Monitoring

The Medical Records Management Team will review this procedure in three years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix I.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

UHL Healthcare Records Retention, Disposal and Preservation Procedures

University Hospitals of Leicester NHS
NHS Trust

H1 Introduction

The General Data Protection Regulation States that 'Personal Data processed for any purpose(s) shall not be kept for longer than is necessary for that purpose or those purposes.

Whilst the phrase 'longer than is necessary' is not defined in GDPR, the recommendation from the NHS Information Authority (NHSEI) is that Trusts work towards the guidelines published in the Records management: NHS code of practice 2020

It is particularly important under Information Governance requirements that the disposal of records is undertaken in accordance with clearly established policies, which have been formally adopted by UHL and which are enforced by properly authorised staff.

This Procedure is one of a suite of policies and procedures relating to records management and information governance and are shown below:

- Healthcare records creation procedure
- Healthcare records locating and requesting procedure
- Healthcare records maintenance procedure
- Healthcare records security and storage procedure
- Healthcare records tracking procedure
- Healthcare records transportation procedure
- Healthcare records retention, disposal and destruction procedure
- Specialty healthcare records procedures (where required)

H2 Scope

This procedure applies to all UHL Trust staff who handle healthcare records and are responsible for records destruction and retention.

The Medical Records department is responsible for the destruction of the core records and the marking of records to be retained for longer than the set retention period.

Health care professionals within the Clinical CMGs of the Trust are responsible for identifying where healthcare records need to be retained for longer than the set retention period.

This procedure will assist staff in identifying how long records should be kept, and for disposing of those no longer required for the intended purpose, (either by destruction or transfer to an archive).

This procedure incorporates retention schedules for health care records that were previously incorporated into the now obsolete Trust Retention of Records Policy B10/2004

H3 Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

- The Public Records Act 1958;
- The General Data Protection Regulation;
- The Freedom of Information Act 2000;
- The Common Law Duty of Confidentiality,
- The NHS Confidentiality Code of Practice,
- Access to Health Records Act 1990; and
- International Standard ISO 15489, Records Management

and any new legislation affecting records management as it arises.

H4 Procedure Standards

H4.1 Records Destruction

The methods used for destruction of confidential health records, and any other documents which could identify a patient, must ensure that the confidentiality of patients is fully maintained throughout the process of destruction.

Selection of records for retention and disposal takes place in two stages.

- Records destroyed in line with retention schedules
- Do Not Destroy : Review by Dept/Post in MM/YY

The first, when the records have passed out of active use. At this point records are destroyed. Inactivity of the records should be calculated as per the retention schedule (see table in paragraph 4.3) from the last activity recorded in the clinical record. Inactive records which have crossed the minimum retention period should be destroyed following the appropriate checks (refer to the **Healthcare Records Staff Destruction Guidance** see Schedule 1 to this appendix)

The second are for those records which have been identified as valuable for future research or legal requirements and are kept for further review at a later date.

H4.2 Do Not Destroy Process (DND)

Records to be retained for longer than national guidelines for retention and destruction should be identified by health care professionals within the clinical CMGs if they identify that the record meets any of the following criterion:

• Value for research purposes
• Value for legal purposes
• Value for historical purposes i.e. sampling for permanent retention at the public record office
• Identified familial illness

The records must be clearly identified with a ‘DO NOT DESTROY’ Label. The label should be completed by the area requesting that the notes be retained and should include a review date.

In the event of no review date, the healthcare records will be destroyed according to the Trust’s retention policy schedule.

The label template is available from the Medical Records Service Manager.

The Trust follows the guidelines published in the Records management 2021: NHS code of practice:

Some departments maintain their own Destruction Policies e.g. Department of Oncology hold the Radiotherapy Note Destruction Policy.

H4.3 Healthcare Paper Records Retention periods as per NHS Records Management code of practice 2021

Adult Health Records (not covered by any other section in this schedule)	8 years after last entryDeceased patients – 8 years after death if died in UHL, otherwise 8 years after the conclusion of treatment
Childrens records (including midwifery)	Until the patients 25th birthday, or 26th if young person was 17 at conclusion of treatment; (e.g. born 1990, retained until 2017), or 8 years after patient's death if death occurred before 18th birthday.
Dental Records	15 years after last entry
Obstetrics, maternity, ante-natal and postnatal records	25 years after last entry
Cancer/Oncology	30 years from diagnosis or 8 years after death
Creutzfeldt-Jakob disease records	30 years after last entry or 10 years after death
Transplant records	30 years after last entry or 8 years after death if an adult, 25 years for a child. Refer to guidance issued by the Human Tissue Authority
All other records	Please refer to schedule in the NHS Records code of practice 2021

H4.4 Selecting Healthcare records to be destroyed

Identification of core healthcare records ready for destruction (culling) is a function that is only undertaken by Medical Records staff. (Refer to Schedule 1a - The process for identifying healthcare records for destruction)

Healthcare Records are destroyed or disposed of in a confidential manner. The records are not handled in the same way as domestic waste, due to safeguards in maintaining patient confidentiality. UHL use a specialist company to destroy confidential material. This process is undertaken on site. The specialist company will maintain security of the information up to the point of destruction and their employees are bound by confidentiality.

The patient's electronic (HISS) record will be updated to reflect the healthcare records have been destroyed, the date destroyed and the patient number withdrawn from use in both HISS and TrackIT.

H4.5 Records for permanent preservation

The Public Records Act 1958 requires organisations to select records for permanent preservation. Selection for transfer under this Act is separate to the review of records for destruction, it is designed to ensure the permanent preservation of a small core of key records that will:
- enable the public to understand the working of the organisation and its impact on the population it serves
- preserve information and evidence likely to have long term research or archival value

Selection of records must take place at or before the records 20 years old (e.g 20 years after last use). If records are marked for permanent preservation by the relevant specialty, medical records will ensure the reason is valid according to the

records management code of practice 2021 before liaising with the Place of Deposit (POD), in Leicester's case this is the public records library in Wigston.

H5 Monitoring

The Medical Records Management Team will review this procedure in two years or sooner if there are changes to legislation and / or the processes carried out.

A yearly audit will be undertaken to check a sample of patient's records to ensure elements of this procedure are adhered to. This will be conducted by the Medical Records Management Team.

The audit criteria for this procedure and the process to be used for monitoring compliance are detailed in Appendix I.

All incidents/ near misses in relation to this procedure must be reported on the Trusts incident reporting system, Datix, and appropriate actions taken by the lead person within the responsible area.

Schedule 1 (of Appendix H) – Healthcare Records Destruction Guidance

Healthcare Records Staff Destruction Guidance

1. Introduction

The General Data Protection Regulation States that 'Personal Data processed for any purpose(s) shall not be kept for longer than is necessary for that purpose or those purposes.

These guidelines are to inform the Medical Records staff of the process when destroying or retaining patient case notes paper or electronic.

2. Retention of Notes

Case notes can be destroyed 8 years after the last hospital attendance with the following exceptions:-

2.1 Patients under 25 years old

These case notes must not be destroyed until the patients 25th birthday, or 26th if young person was 17 at conclusion of treatment. (e.g. born 1990, retained until 2017, **or** 8 years after patient's death if death occurred before 18th birthday.

2.2 Patients with a Do Not Destroy (DND) Sticker on the Case note Folder

It may be necessary to retain notes longer than their minimum retention period. In these cases, notes should be identified with a 'Do Not Destroy' sticker, and the TrackIT record marked appropriately. It is the responsibility of the department that wants the records keeping to place the sticker on the notes, when notes with these stickers are returned to any medical records library, medical records staff will update TrackIT with a DND review date.

Any notes identified as having reached their review date should be returned to the appropriate department for a decision.

3. Destruction

Notes that have been identified as being suitable for destruction will be shredded to maintain patient confidentiality.

3.1 Prefixed G, R, F sets (live or deceased) and deceased U sets

When a G, R, F or deceased U set becomes eligible for destruction the case note number needs to be tracked to the borrower code **DESTROYED** within TrackIT prior to withdrawal on HISS. Any case notes identified on TrackIT as 'not for destruction' (via DND flag on the tracking screen) can be pulled out and will have the correct stickers attached to the front of the case note and be returned to the library.

3.2 Prefixed 'U' notes (excluding deceased U sets – See 3.1 above)

Where a U set becomes eligible for destruction it is important **NOT** to withdraw the casenote number in HISS as the number may need to be regenerated in the future. Instead just track the casenote to the borrower code **DNN** (Destroyed No Notes) within TrackIT and add the comments: **'Historic record dest, remake using this original U number for future activity'**

3.3 HISS

With the exception of U sets the HISS system needs updating for all other sets of casenotes that are destroyed.

Using the **PMI Add/Revise** function the case note number should be withdrawn and the home location code changed to DEST. If the set of notes is an amalged set (LRI and LGH historic notes combined) then both numbers will need withdrawing and the home location changing.

When using the **PMI Add/Revise** function check the date of birth of the patient to ensure that notes for under 25 year olds are not being destroyed and also check the episode screen for any attendances in the last 8 years. Any errors found need to be reported to the relevant site manager and the notes returned to file.

The culling and checking of the physical case note folders and the marking of the HISS system needs to be done by two separate members of medical records staff as a safety check to ensure that notes are not destroyed in error.

3.4 TrackIT

When a case note number is withdrawn in the HISS system, the case note number will be withdrawn automatically in TrackIT.

4. Notes Destroyed in Error

A Datix incident must be recorded for any instances of either electronic or paper records being destroyed or withdrawn in error

4.1 Electronic records withdrawn in error:-

If a case note number is withdrawn in HISS it is automatically withdrawn in TrackIT, this means that the number cannot be requested or tracked. Although the HISS system allows you to un-withdraw a case note number this will not un-withdraw it in TrackIT.

If you withdraw a number in error on the HISS system you must contact a member of the Medical Records Management team as soon as possible who will arrange for the patient to be given another case note number.

4.2 Paper records destroyed in error:-

If a set of paper case notes have been destroyed in error then a new folder needs creating which should contain as much information as is available including any pathology results and secretary letters that can be retrieved. A letter must be added to the folder detailing when the case notes were destroyed and when they were recreated and what information is believed to have been lost.

This schedule should be read in conjunction with Appendix H of the Records Management Policy

Appendix I- Access to Health Records Guidelines

Access to Health Records Guidelines	University Hospitals of Leicester NHS NHS Trust **Previously policy - B22/2003**

1. Introduction and who Guideline applies to

This guideline is for all access to health records staff to assist them in answering any queries or questions they may be asked by any requestor. This guideline contains all the information they may require in order to complete their job role when dealing with a variety of different types of requests from different requestors. In addition this guidance can be used by all UHL staff members so that they know the correct process in releasing medical records to requestors.

2. Guideline Standards and Procedures

Who Has a Right to Apply?

2.1 The patient.

2.2 Any person authorised in writing, to apply on behalf of the patient (see below also).

2.3 In England and Wales, the person having parental responsibility for a child under 16, or if the record holder feels it is in the child's best interest (see below also). However, where the patient is under age 16 but is mature enough to understand the meaning of the application (termed as being Gillick Competent), the patient can refuse to allow this access.

2.4 A child (a person under the age of 16 years) who, in the view of the appropriate Healthcare Professional, is capable of understanding what the application is about can prevent a parent from having access to the record. If the child is not capable of understanding the nature of the application, in the view of the appropriate Healthcare Professional, then the holder of the record is entitled to deny access if it would not be in the child's best interest (see below also).

2.5 Any person appointed by the Court, to manage the affairs of a patient of any age, who is deemed to be incapable (see below also).

2.6 The applicant must declare that they are entitled to apply for access to the health records referred to. The applicant may also give their authority to a Solicitor, or any one else they choose, to obtain copy records of the patient, on behalf of the applicant.

2.7 Further enquiries may be needed to confirm the authenticity of applicants other than the patient before access is given. NB proof of identification will be required for access.

If the applicant is acting on the patient's behalf then it must be established in what capacity they are making the application:

Records for Patients under the Age of 16

2.8 The applicant must have parental responsibility. This will be by way of one of the following:

2.9 The applicant is the child's natural mother (and there is no Adoption Order or other Court Order to the contrary). We have to take the applicants / Solicitors written word for this at face value. This is often referred to as acting in loco parentis and is where the patient is under age 16 and is incapable of understanding the request.

2.10 Also, where the patient is under age 16 but is mature enough to understand the meaning of the application and giving authority (termed as being Gillick Competent) and has consented to the applicant making this request, the authorisation of the patient and / or mother should be given. Again, we have to take the applicants / Solicitors written word for this at face value.

2.11 The applicant is the child's natural father and was married to the child's natural mother at the time of conception or birth of the child or subsequently marries the mother at a later stage. NB the father does not necessarily still have to be married to the child's natural mother. He could be legally separated or divorced from her. Also, this whole point only applies providing that there is no Residents Order or other Court Order to the contrary. We can accept a Solicitor's written confirmation of this. Marriage / Divorce papers are not necessary.

2.12 The applicant is the child's natural father but was not married to the child's natural mother at the time of conception or birth of the child, but there is a parental responsibility agreement between both parents, which has been passed by a Court of Law. Documentation will exist if this is the case, and a photocopy of it should be obtained.

2.13 The applicant has parental responsibility by way of a Court Order. This would be by way of a Parental Responsibility Order or a Residence Order. This could apply to the child's natural father, or to a grandparent or other relative. A Care Order in favour of Social Services grants parental responsibility to a Local Authority. Documentation will exist if this is the case, and a photocopy of it should be obtained

2.14 For any child whose birth is registered on or after 1 December 2003 then if the father's name appears on the child's birth certificate the father will have joint parental responsibility.

2.15 If the applicant does not satisfy any of the above criteria, then access to the records will be denied, unless the applicant can provide the written authority of someone who has got parental responsibility. Living with the mother, even for a long time, does not give a father parental responsibility and if the parents are not married, parental responsibility does not automatically always pass to the natural father if the mother dies.

Records for Patients over the Age of 16

2.16 Patients capable of managing their own affairs - the applicant must have the written authority of the patient if they are capable of managing their own affairs.

2.17 Patients incapable of managing their own affairs - the applicant must have proof that they have the authority to act on behalf of the patient. This will be by way of one of the following:

a) They have been appointed by the Court to manage the patient's affairs. Documentation will exist if this is the case, and a photocopy of it should be obtained.

b) They are the deceased patient's personal representative. Documentation will exist if this is the case, and a photocopy of it should be obtained.

Other Considerations for All Records for Patients of Any Age

2.18 A Healthcare Professional has also got the discretion not to release records to an applicant if they consider it to be in the best interests of the patient at that time. They would be responsible for their clinical judgement.

2.19 The only other over riding rule would be where a court order required disclosure of the medical records in question to the applicant. In these circumstances advice should be sought from Legal Services so that consideration could be given to seeking revocation of the court order so as to protect a patient's rights.

Deceased Patient Records

2.20 There are also a range of public bodies that have lawful authority to require the disclosure of health information. These include the Courts, legally constituted Public Inquiries and various Regulators and Commissions e.g. the Audit Commission and the Care Quality Commission. 2 In these cases the common law obligation to confidentiality is overridden.

2.21 The Access to Health Records Act (AHRA) 1990 provides certain individuals with a right of access to the health records of a deceased individual. These individuals are defined under Section 3(1)(f) of that Act as,

'the patient's personal representative and any person who may have a claim arising out of the patient's death'. A personal representative is the executor or administrator of the deceased person's estate.

Record holders must satisfy themselves as to the identity of applicants who should provide as much information to identify themselves as possible. Where an application is being made on the basis of a claim arising from the deceased's death, applicants must provide evidence to support their claim. Personal representatives will also need to provide evidence of identity.

A request for access should be made in writing to the record holder ensuring that it contains sufficient information to enable the correct records to be identified. Applicants may wish to specify particular dates or parts of records which they wish to access.

Exemptions to disclosures of information relating to deceased patients

2.22 Where a patient has died, access should not be given to information, which in the opinion of the holder is not relevant to any claim arising out of the death. Also, if the patient has died and the record includes a note made at the patient's request that he / she did not wish access to be given to their personal representative or to any person having a claim arising from their death, access will be refused.

In addition, the record holder has the right to deny or restrict access to the record if it is felt that:

- disclosure would cause serious harm to the physical or mental health of any other person;
- or would identify a third person, who has not consented to the release of that information.

Disclosure in the absence of a statutory basis

2.23 Disclosures in the absence of a statutory basis should be in the public interest, be proportionate, and judged on a case-by-case basis. The public good that would be served by disclosure must outweigh both the obligation of confidentiality owed to the deceased individual, any other individuals referenced in a record, and the overall importance placed in the health service providing a confidential service. Key issues for consideration include any preference expressed by the deceased prior to death, the distress or detriment that any living individual might suffer following the disclosure, and any loss of privacy that might result and the impact upon the reputation of the deceased. The views of surviving family and the length of time after death are also important considerations. The obligation of confidentiality to the deceased is likely to be less than that owed to living patients and will diminish over time.

Another important consideration is the extent of the disclosure. Disclosing a complete health record is likely to require a stronger justification than a partial disclosure of information abstracted from the record. If the point of interest is the latest clinical episode or cause of death, then disclosure, where this is judged appropriate, should be limited to the pertinent details.

2.24 This guidance is not intended to support or facilitate open access to the health records of the deceased. Individual(s) requesting access to deceased patient health information should be able to demonstrate a legitimate purpose, generally a strong public interest justification and in many cases a legitimate relationship with the deceased patient. On making a request for information, the requestor should be asked to provide authenticating details to prove their identity and their

relationship with the deceased individual. They should also provide a reason for the request and where possible, specify the parts of the deceased health record they require.

2.25 Relatives, friends and carers may have a range of important reasons for requesting information about deceased patients. For example, helping a relative understand the cause of death and actions taken to ease suffering of the patient at the time may help aid the bereavement process, or providing living relatives with genetic information about a hereditary condition may improve health outcomes for the surviving relatives of the deceased.

2.26 In some cases the decision about disclosure may not be simple or straightforward and a senior lead on patient confidentiality, for example the organisation's Caldicott Guardian or Information Governance lead, should be consulted. In the most complex cases it may be necessary to seek advice from the Assistant Director of legal services.

Receiving Subject Access Request under the GDPR 2018

2.27 A request for access to health records in accordance with the GDPR (The GDPR refers to these as a subject access request) should be made in writing to the data controller. However, where an individual is unable to make a written request it is the Department of Health view that in serving the interest of patients it can be made verbally, with the details recorded on the individual's file.

The requester should provide enough proof to satisfy the data controller of their identity and to enable the data controller to locate the information required. If this information is not contained in the original request the data controller should seek proof as required. Where requests are made on behalf of the individual patient the data controller should be satisfied that the individual has given consent to the release of their information.

As good practice the data controller may check with the applicant whether all or just some of the information contained in the health record is required before processing the request. This may eliminate unnecessary work by NHS staff. However, there is no requirement under the Act for the applicant to inform the data controller of which parts of their health record they require.

Where an access request has previously been met the Act permits that a subsequent identical or similar request does not have to be fulfilled unless a reasonable time interval has elapsed between.

Appropriate health professional to consult

2.28 The Data Protection (Subject Access Modification) (Health) Order 2000 sets out the appropriate health professional to be consulted to assist with subject access requests as the following:

The health professional who is currently, or was most recently, responsible for the clinical care of the data subject in connection with the information which is the subject of the request; or

Where there is more than one such health professional, the health professional who is the most suitable to advise on the information which is the subject of the request.

When Access to Records may be denied or partially excluded

Within the Act there is provision for some information to be withheld:

2.29 The patient does not have to be told that information has been withheld because that in itself could be damaging to them.

2.30 The patient is not, however, prevented from asking the practitioner whether the full record has been made available, and may apply to the Courts if they are dissatisfied with the answer.

2.31 The fact that a record has not been prepared in anticipation that it might be opened is no justification for denying access. Also, fear of legal action is not a reason for denying access.

Healthcare Professionals are advised that records should be compiled on the assumption that they will be opened to patients and / or the Courts.

2.32 Access shall not be given unless the holder is satisfied that the applicant is capable of understanding the nature of the application and the meaning of the authorisation.

2.33 If in the opinion of the holder of the record, the information may cause serious harm to the physical and / or mental health of the patient and whether access would be in the best interests or wishes of the patient, access shall not be given.

2.34 Access to health records would disclose information relating to or provided by a third person who has not consented to that disclosure unless:

- The third party is a health professional who has compiled or contributed to the health records or who has been involved in the care of the patient.
- The third party, who is not a health professional, gives their consent to the disclosure of that information.
- It is reasonable to disclose without that third party"s consent.

2.35 Where information that is adjudged to be harmful is withheld, an appointment should be made for the applicant to inspect the remainder of the record with the Healthcare Professional

Patients living abroad requiring access to their health records

2.36 Former patients living outside of the UK who had treatment in the UK have the same rights under GDPR to apply for access to their UK health records. An NHS organisation should treat these requests the same as someone making an access request from within the UK.

2.37 Original health records should not be given to patients to keep/take to a new GP outside the UK. In instances when a patient moves abroad a GP may be prepared to provide the patient with a summary of the patient"s treatment. Alternatively, the patient is entitled to make a request for access to their health record under GDPR to obtain a copy.

Requests for personal data other than medical records

2.38 An individual may ask for personal data other than medical records that the Trust holds on them. This could include the new category of unstructured manual data held by public authorities as created by the Freedom of Information Act 2000.

2.39 Such applications may include requests for copies of incident report forms, minutes of meetings where they were discussed, emails relating to them and any other reports or correspondence of which they are the subject.

2.40 Any request for personal information that does not relate to the requestor (or the individual they are making the request on the behalf of) should be treated as a request under the Freedom of Information Act and forwarded to Trust Administration to process either by telephone – 0116 258 8590 or by e-mail foi@uhl-tr.nhs.uk

2.41 Where the request is for a combination of personal and non-personal data, the Access to Health Records department should liaise with Trust Administration to ensure a combined response. For further information see the UHL 'Freedom of Information Act 2000 and Environmental Information Regulations Policy'.

2.42 Where an individual requests access to unstructured manual personal data, the Trust can ask the individual for further information in order that this data can be located.

2.43 Any requests for other types of personal data will be sent to the Freedom of Information Lead within the directorate(s) concerned to collate. Once collated this data should be returned to

the Access to Health Records Officer dealing with the case and reviewed by the Information Governance Manager before being dispatched.

Informal access, sharing of information

2.44 Where all conditions outlined above are met, informal access from patients should be encouraged during the period of their care. As we move into a period of openness within the NHS, the more the information we hold should be actively shared with patients. This will have a positive effect on the accuracy of health records and will aid patient recall of their consultation.

2.43 The 'copying letters to patients' project, which gives patients the right to a copy of any correspondence about them sent between two health professionals, will also enhance this process. A patient may not want to receive a copy of a letter at the time that it is written; they will however retain the right of access to that letter at any point in the future.

Time Limits for Access

2.44 The Act imposes very specific duties upon us, which have to be carried out within a very tight timescale.

From receipt of the application form, 14 days are allowed if the record holder needs more information, either to identify the record(s) asked for, or to check the identity of the person applying for access.

2.45 After that the Trust will endeavour to comply with subject access requests within 21 days where reasonably possible, and in any case within the 30 days specified in the GDPR 2018.

Failure to comply gives the applicant a right of action in the County Court or High Court. It is therefore essential that all applications be processed as a matter of priority, thereby minimising risk to the organisation.

Where staff request access

2.46 Members of UHL staff should go through the standard procedure for accessing their own health records.

2.47 On no account should staff attempt to access their own records, those of friends or family members, or anyone else without a legitimate business reason. This includes any information held electronically. Staff members found to be doing so without a legitimate business purpose will be subject to the Trust's disciplinary procedure.

Access to Health Records Charging Structure

2.48 Nil charge for viewings, paper copies or electronic copies of patient records. Delivery charge is only payable if paper copies are provided and exceeds 1000 pages. Where a request is deemed excessive a charge can be made, for example multiple requests per year for the same records

Viewing health records

2.49 If it is agreed that the patient or their representative may directly inspect their health records, it should be considered whether access should be supervised by a health professional or a lay administrator. A lay administrator is a neutral person who can oversee the viewing and ensure that the record remains safe. In these circumstances the lay administrator must not comment or advise on the content of the record. If the applicant raises queries an appointment with a health professional should be offered.

Amendments to Health Records

2.50 If the applicant considers that there are mistakes or inaccuracies in the record they can ask the record holder for a note to be made in the records stating their opinion. If the practitioner agrees that the information is inaccurate, he / she should make the correction. Care must be taken not to simply obliterate information, which may have significance for the future care and treatment of the patient, or for litigation purposes.

2.51 Where the health professional and patient disagree about the accuracy of the entry, the Department of Health recommends that the data controller should allow the patient to include a statement within their record to the effect that they disagree with the content.

It should be understood that in Law nothing may be erased from a paper health record but a correction may be added.

2.52 If the patient is unhappy with the outcomes outlined in paragraphs 2.50 to 2.51, there is the option of taking this more formally (See Complaints at paragraph 2.54).

2.53 A copy of any correction or note should be supplied to the patient. No fee may be charged for this.

Complaints Concerning Application

2.54 If the applicant feels that they have not been fairly treated and that the holder of the record has not complied with the Act, then they should first complain through the normal UHL complaints procedure.

In the first instance, the health professional involved should arrange to have an informal meeting with the individual to try to resolve the complaint locally.

If the issue remains unresolved, the patient should be informed that they have a right to make a complaint through the NHS complaints procedure.

Ultimately, the patient may not wish to make a complaint through the NHS Complaints Procedure and take their complaint direct to the Information Commissioner's Office, it they believe the NHS is not complying with their request in accordance with the Data Protection Act.

Alternatively, if the patient wishes to do so, they may wish to seek legal independent advice.

Additional Information

2.55 Under the Access to Medical Reports Act 1988, individuals can apply to access medical reports prepared for employment or insurance purposes.

In most cases access under the Act will be straightforward. However, there will be instances where a detailed knowledge of the Act and its implications are vital.

2.54 The Information Commissioners website also provides some useful information.

http://www.dataprotection.gov.uk

Any further advice should be directed to the Information Governance Manager or Corporate & Legal Affairs.

3. Education and Training

All access to health records staff are required to complete cyber security/data protection level 3 training on a yearly basis.

On arrival all new staff will be given training and access to a mutitude of systems and databases used by UHL to complete their job role.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Completed requests	Weekly/monthly/yearly stats	Team Leader	Weekly/monthly/yearly	Monthly report sent to all staff and management

5. Supporting References (maximum of 3)

NONE

6. Key Words

AHR, Access to health records, GDPR

CONTACT AND REVIEW DETAILS	
Guideline Lead – Ben Hardy (Medical Records Manager)	**Executive Lead**
Details of Changes made during review:	

Appendix J – Adopted Childrens records procedure

Adopted childrens records procedure	University Hospitals of Leicester NHS NHS Trust

1. Introduction

This procedure is for the management of hospital health records when a child is placed for adoption, and the changes that are required to those health records when the child is then legally adopted.

When a child is placed with adopters, up until the time when the legal adoption order is granted, the child remains a child in care and must continue to be registered as their birth surname, and NHS number. The child may not be known by a new surname *Adoption and Children Act 2002 (Ch3,section 28 (3a)*

It is imperative that information is not disclosed inadvertently for a looked after child. Although the name and NHS number are not changed unless a child is actually adopted, the safeguarding of the child is paramount in these cases. If a child is in the care of anyone other than their biological parent/s then the information regarding current address and attendances including access to health records must not be disclosed to the birth parents even though they have parental rights.

For any enquiries regarding the current adoptive/care situation for a looked after child you can email the LPT looked after childrens service on:
lep-tr.fypclookedafterchildrenadmin@nhs.net

It is national practice that once an adoption order has been granted by the courts the NHS back office issues a new NHS number to the child and new health records should then be created under the new name and NHS number.

There are several principles at work here which include confidentiality about the adoptive placement (which may include a security risk) the issuing of a new identity and the fact that the medical records often contain third party information (safeguarding or family history of birth parents etc) and who are no longer legally related to the child.

Current adoption legislation requires that all adopted children are given a new NHS number, and that all previous medical information relating to the child is put into a newly created health record. Any information relating to the identity or whereabouts of the birth parents MUST not be included in the new record. The change of name, NHS number and transfer of previous health information into a new health record should take place for both GP records and hospital records, and any other health records as appropriate.

Whilst changing or omitting information from medical records would usually be contrary to ethical and professional guidance, this is not the case for the records of adopted children as there is an England wide system requirement that it takes place. The following information has been approved by the IG Policy team within the Department of Health:

• The Trust must not make any changes that conceal or alter the patient's clinical history. However, steps must be taken to prevent disclosure of their pre-adoptive identity, perhaps blocking out all references to the previous name and any information that may identify members of the birth family.
• The pre-adoptive identity should be regarded as confidential and the Trust must ensure that they have robust systems in place to avoid disclosure and/or access.

2 Scope

These guidelines describe the processes and procedures for dealing with the paper and electronic health records of adopted children within the Trust

3 Definitions

Nerve Centre – The Trust EPR (electronic patient record) system that is used in ED and other areas across the Trust and holds clinical and personal identifiable information

Hospital Information Support System (HISS) - The University Hospitals of Leicester (UHL) patient administration system

PDS - NHS England Patient Database System

NHAIS - National Health Authority information system

Adopted child - A child who has been adopted and has been given a new NHS number by the NHS back office

Prospective Adoptive Parent - This is an adult who has some parental responsibility for children who have been placed with them for adoption by the local authority.

Adoptive Parent - An adult who has full parental responsibility for children who they have legally adopted. They should be known as mother/father once the child is legally adopted, and not adoptive mother/adoptive father.

Prospective adoptive placement - This is a term used when a child moves into a home to live with prospective adopters but the adoption order has not yet been granted.

Looked after child - This term includes both children 'in care' and accommodated by local authorities/Health and Social Care Trusts, including unaccompanied asylum seeking children and those children where the agency has authority to place the child for adoption.

Legally adopted - This means when an adoption order has been granted by court and parental responsibility for a child transfers from birth parents to adoptive parents.

4 Roles and Responsibilities

All staff who are informed about an adoptive child that has received a new NHS number need to be aware of this procedure and follow their respective instructions

- Medical Records Managers

Medical Records Managers are responsible for the core patient healthcare records and the management of the records libraries. They have an up to date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information.

- All NHS employees

Under the Public Records Act all NHS employees are responsible for any records they create or use in the course of their duties.

5 How do we receive the information?

The information regarding an adopted child can be received in UHL from numerous sources including patients GP, adopted parent, LPT adoption health team, NHS Digital, NHS back office, another hospital etc.

Adoptive parents will receive a letter and New NHS card for an adopted child and as such this should be provided to the Trust if it is a parent that is informing us. They will also have an adoption order which should also be provided before any records are updated to ensure the safeguarding of the child.

6 What do we do with the information?

As well as information coming from numerous sources, it can also be received by numerous departments including medical records, data quality team, a service within paediatrics currently treating a child, the emergency department etc, any clinical service, PILS etc.

To ensure the patient has continuity of care, ideally a transfer of clinical information must be taken from the previous health record and transferred onto the new clinical record both electronic and paper. However in reality at UHL, it is sufficient to update the existing records (see process below)

•The new guardians of the patient must NOT be disclosed as ‘adoptive’ parents at any point within the record. They will be simply recorded as ‘parents’ where applicable.
•Any information relating to a patient’s previous identity or, the identity and whereabouts of birth parents must not be included within the updated record.

Any service that receives this information needs to adhere to the following process:

- Information is received
- Documents should be checked as per section 5
- Information is then sent to the Data Quality mailbox who will action HISS
- DQ will change the NHS number and any other relevant details on HISS this should include any new name, address, GP and Next of Kin details

- DQ should also ensure that any previous details are not saved in HISS by deleting them from the relevant section, this should include previous address/es and previous name as a minimum. Functionality within HISS allows for the deletion of historic data and that needs to be assured in these cases
- DQ will then inform the medical records managers via the generic mailbox
- Medical records will arrange for the UHL core casenotes to be located and then remove all traces of previous names, addresses, birth parent etc as per the guidance in section 4 and change the relevant demographics that have already been updated on HISS by printing of new ID sheets and labels
- Medical records will add a note to the front inside of the folder that states 'no information is to be given without first seeking approval from the Access to Health Records department. This is relevant to requests for access to the medical records for non medical reasons only. If notes are required for the on-going treatment of the patient, then it is ok to release and share the information
- Medical records will check to see if a patient is registered with any other service that use specific records and if so will inform that service who needs to follow the same process for changing details.

Appendix K – Procedure for Management of Records of transgender patients

Procedure for the management of records of transgender patients	University Hospitals of Leicester NHS NHS Trust

1. Introduction

This document sets out the University Hospitals of Leicester (UHL) NHS Trusts procedure for managing healthcare records for Transgender patients within UHL. The aim of this document is to provide staff with guidance around the legal requirements and practical processes for record keeping.

Information and guidance has been taken from the Records Management code of practice 2021 page 106.

Records relating to these patients are often seen as more sensitive than other types of records, while all health and care records are subject to confidentiality restrictions, there are specific controls for information relating to patients with a gender recognition certificate or GRC.

The use and disclosure of the information contained within these records is subject to the Gender Recognition Act 2004 or GRA which details specific restrictions and controls for these records. The GRA is clear that it is NOT an offence to disclose protected information relating to a person if that person has agreed to the disclosure. The GRA is designed to protect trans patients and should not be considered as a barrier to maintaining historic medical records where this has been consented to by the patient.

There is an established process in place with NHS Digital for patients undergoing transgender care in relation to the NHS number and the closing and opening of new spine records. In practice nearly all actions relating to transgender records will take place between the GP and the patient regarding clinical care so that if a patient is referred to UHL it should be made clear whether the referral is under the new or old identity. If reference to the old identity is there then consent can be assumed to keep the historic medical information and the personal details be updated, if the referral is purely under new details and no reference to old details is present then a new record should be created with the new details. Patients should however be offered ways to maintain their historic records, this could include editing previous entries and removing references regarding previous name and gender language, any decisions regarding their record must be respected and actioned accordingly.

Any patient can request their gender be changed in a record by a statutory declaration, but the GRA gives additional rights to those with a GRC. The formal legal process is that a gender reassignment panel issues a GRC and at this time a new NHS number is issued and a new record can then be created if at the request of the patient. The content of the new record will be based on explicit consent under common law.

2 Definitions and Abbreviations

Transgender Person

This is a person who has a gender identity or gender expression that differs from that which is expected based on their birth sex.

Trans
The expression trans is an inclusive term for a person who is transgender or transsexual. The term trans man refers to a man who has transitioned from a woman to a man, and trans woman refers to a woman who has transitioned from a man to a woman.
Personal Demographic Service (PDS)
This is the national electronic database of NHS patient details such as name, address, date of birth and NHS number.
Gender Reassignment
The process of transitioning from the gender assigned at birth to the gender the person identifies with. This may involve medical and surgical procedures. Many people simply call this process transition.
In addition to undergoing medical procedures, trans people who go through sex reassignment therapy usually change their social gender roles, legal names and legal sex designation. Transition describes the point at which a permanent change of gender role is undertaken, in all spheres of life - in the family, at work, in leisure pursuits and in society generally. Some people make this change gradually, whereas others may make changes more quickly.

2 How and what information may we receive?

A patient wishing to be known as a different gender may present this information in a variety of ways. The guidance below relates to three of the most common scenarios experienced within The Trust. The information can be received direct from a patient or a patient representative, the GP or referring clinician or via the data quality team who get an immediate HISS alert if either the NHS number or sex of a patient is updated.

Change Of Name
A patient may request to be known as a different name and has legally changed this using the Deed Poll office. In these circumstances a patient must change their name, using their deed poll certificate, with their General Practitioner (GP). The GP practice will then note this change by updating The Spine.

A simple change of name does not require a new identity or record. A patient can request to be known by a different name or title at any time, regardless of having a deed poll change certificate. The sex of the patient however, must not be changed in these circumstances. The patient record must still show the same gender.

Potential Transition
In some cases a patient may wish to live as a different gender without fully transitioning. This also usually occurs before a patient will undergo a full gender reassignment in order to ensure that this is truly what the patient wishes.
They do not need to have a Gender Recognition Certificate for this to be changed.

Full Gender Reassignment
A patient must discuss their wish to transition with their GP in the first instance. The patient is then able to apply for a Gender Recognition Certificate in order to legally be considered for their acquired gender. Once a certificate has been issued, the patient is then lawfully recognised under

their new gender and has all rights appropriate to that sex. The individual may choose to retain their original health record if they wish to.

Process followed by the patients GP

- The patient can write a 'statutory declaration'; they may have a deed poll document, or they may simply make the request. This request should be in writing, signed by the patient, stating their new name and gender. This is sent to the local CCG by either the patient or via their GP.
- •The GP will write to the Registration Office notifying them of the requested changes. The GP may write a letter of support confirming the gender role change and that this change is intended to be permanent, but this is not a requirement.
- •The Registration Office then writes to the National Back Office (NBO). The NBO will create a new identity with a new NHS number and requests the records held by the patient's GP are amended.
- •On receipt of the new record, the GP surgery changes any remaining patient information including the gender marker, pronouns and names. This information will be updated via The Spine
- When a patient is referred to UHL it is the responsibility of the referring GP to ensure the appropriate personal information as agreed with the patient is in the referral

3 What do we do with the information?

Change of Name and/or title:
This should be updated on HISS and/or any other electronic system and within the paper records at the request of the patient, it is usual to receive this in writing however it is not a legal requirement but it is best practice to enter a note within the paper records as to the conversation that was had with the patient, by whom and when for governance reasons.

Potential or Full gender reassignment patient:
If a referral is received within UHL under a new gender and/or NHS number, UHL services must register the patient on HISS with their new details. If it is known or found that an existing record exists with open attendances e.g open OP referral or waiting list episode, this must have the episode ended and the patient discharged. The episode can then be recreated on the new record under the new identity details. Please inform the Data Quality team who can end and recreate these episodes for you.

If the referral references previous gender/NHS number/hospital attendances etc then it can be assumed that the patient has consented to existing clinical information to be made available for the new referral and in which case any existing HISS or other clinical system record can be updated to the new details rather than a new record created.

Once this process has taken place, any new HISS record and NHS number will have no reference to the patient's birth gender. It is the role of the GP to explain to the patient that they will no longer be contacted regarding screening programs relating to their sex at birth. It is the decision of the patient whether this information and future screening options is added onto their new care record.

If a patient attends under their new identity with new records and states that they would like their previous medical records information included in their current record then please inform medical records and Data Quality who can undertake this for the department. A record of the conversation and request with the patient should be entered in the medical records.

Information from HISS alerts for the Data Quality teams

In the case of the data quality team identifying that a new NHS number and/or identifiers for a patient have been updated on HISS, they should liaise with the person updating to ascertain under which circumstances they are updating these details. If it is found that the patient/referral requires historic information to be kept, then the changes to HISS can be accepted.

If, however it is found to be an error or it is not clear if the patient has consented to historic information being kept then a new registration must be undertaken and any open episodes on the previous record should be closed and recreated on the new record.

If an old record with current episodes is identified and the information could disclose the previous gender and it is not clear around consent, then a discussion must take place between the patient and clinician. No information should be disclosed until this has occurred. The patient MUST provide explicit consent for this information to be transferred.

In NO circumstances must reference to the change of sex be made either in the PMI comments screen or within the paper records as this in itself identifies that a change of sex has happened and will breach the patients right to privacy under the GRA. The data should just be updated as required.

In these cases, medical records will contact the patient to ascertain their preference regarding the historical clinical information. If the patient is unsure then they need to discuss this with a medical professional involved in their care such as their GP, a gender clinic or a UHL clinician if appropriate and it is the patient's responsibility to then inform UHL as to their decision. Medical Records and Data Quality will then update the records as required.

Appendix L- Monitoring & Audit Criteria

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)
Core Healthcare Records					
Duties	Medical Records Manager	The appropriate duties and responsibilities are being performed	Yearly	The Audit results will be reported to IGSG	CMG/Directorate Managers to be contacted where non-compliance occurs. Lead: Healthcare Records General Manager
Legal obligations	Medical Records Manager	Check records related incidents are recorded and actions implemented where appropriate			
Creation	Medical Records Manager	The records are recorded correctly on the associated computer system The physical records are made to the required standard			
Tracking	Medical Records Manager	A retrospective sample of 5 clinic lists and 2 wards admissions list per site with 5 patient's records (per clinic/ward) being checked to ensure that they are tracked at each stage of the expected route the records would usually take (where applicable)			
Retrieval	Medical Records Manager	An attempt to be made to retrieve a sample of 5 records from their last recorded tracking location The records are in the correct place / order within their location (e.g. alpha / numerical / year)	Yearly	The Audit results will be reported to Information Governance Steering Group	CMG/Directorate Managers to be contacted where non-compliance occurs. Lead: Healthcare Records General Manager
Storage	Medical Records Manager	Records are stored appropriately and securely (observations through walk around)			

Disposal and Destruction	Medical Records Manager	A business object report of records marked as destroyed on HISS / TrackIT generated and a random sample of 50 patients selected to assess: A record of disposal / destruction exists checked to ensure they met the criteria for destruction The records were destroyed confidentially (check arrangements) i.e. shredding bins			
Retained for longer than the retention	Medical Records Manager	A business object report of records marked as 'Do Not Destroy' (DND) on TrackIT is generated and a random sample of 50 patients selected to assess: The physical record is clearly marked 'Do Not Destroy' A review date is recorded The reason for retention is marked / recorded			