



NHS Tayside
Health Records Operational Guidance & Service Operating Procedures

Policy Manager Health Records Service	Policy Group Information Governance
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Policy Established	Last Updated April 2024	Policy Review Period/Expiry April 2026
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This policy does / does not apply to Medical/Dental Staff (delete as appropriate)

UNCONTROLLED WHEN PRINTED

Version Number	Purpose/Change	Author	Date
1.0	Operational Guidance implemented August 2011	Kerry Wilson	
2.0	Operational Guidance reviewed and up-dated	Ruth Anderson	March 2013
Amendments to Version 2.0:			
Section/ Page Number	Detail of amendment	Reason for amendment, if known	
Section 1 Page 4 Retention and Disposal Schedules	Version 1: The management, Retention and Disposal of Personal Health Records – Annex D of the Records Management: Code of practice (Scotland) 2010 Version 2: Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012: Annex B 'The Management, Retention and Disposal of Personal Health Records'.	Up-dated Scottish Government Guidelines.	
SOP No 2 Page 34	1. Opening Statement addition of Clinical Portal		
SOP No 4 Page 37	If carried by hand records should be in a sealed envelope or blue draw string bag."		
SOP 5 Page 39	Murray Royal Fax number updated		
SOP10 Page 46	Inclusion of Clinical Trials		
SOP 14 Page 52	F. Definitions as per the Acts The Application – an application in writing. Health Record – the Health Record, both paper and electronic and related expressions, are defined as being information relating to the physical or mental health of an individual who can be identified from that information, and which has been made by or on behalf of a health care professional, in connection with the care of that individual Section H.3 - Check that the application form has been completed correctly by the applicant or by the representative of the applicant and start the subject to access check lists. The applicant has the right to have his request completed within 40 days of receipt of completed Application for Access to Health Records form. - In personal access requests payment should be received before the process begins		
3.0	Operational Guidance reviewed and updated	Ruth Anderson	November 2013
Amendments to Version 3.0:			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	

Service Operating Procedures	Addition of standard operating procedures relating to SOP 14: handling Subject Access Requests		Recommendation of NHS Tayside Internal Audit Service view of process report NoT19/
Service Operating Procedures	Addition to SOP 15: Filing of loose documentation to include filing of non-clinical documentation		Query raised at Waiting Times Learning Network
4.0	Operational Guidance reviewed and updated	Ruth Anderson	January 2015
Amendments to Version 4			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	
All	All references to "Medical" Records updated to "Health" Records	To ensure consistency	
SOP 19 Requesting Case Records for Audit	Addition to SOPs		
All sections	Reference to secondary storage areas will include Stracathro as well as Claverhouse	Additional secondary storage area	
Amendment to Version 5			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	
Section 2 / Page 33	Update to Service Operating Procedure No 1: Retention, Destruction and Archiving of Health Records to include minimum NHS retention periods and destruction flow chart.	Clearer guidelines required for health records staff culling case records.	
Section 2 / Page 131	Addition of Service Operating Procedure No 20: Recording of Advanced Directives	Requirement for staff in NHS Tayside to be aware of how to record advanced directives on Topas (Patient Administration System) and case records.	
Amendment to Version 6			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	
Section 2 / Page 134	Addition of Service Operating procedure No 21: Procedure for the development of new-updated clinical documentation..	Clearer guidelines required for producing new or updating current clinical documentation.	
Amendment to Version 7			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	
Section 2/ Page 50	Changes made to SOP 11: Splitting of Large Health Records Folders	Change in practice	
Amendment to Version 8			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	
	Review of document to reflect implementation of iFIT and TrakCare		
Amendment to Version 9			
Section/Page Number	Detail of Amendment	Reason for amendment, if know	

SOP 14	SOP 14: Subject Access Requests updated with introduction of GPPR	
Amendment to Version 10		
Section/Page Number	Detail of Amendment	Reason for amendment, if know
SOP 4	Update to SOP after LAER	
SOP 6	Update to SOP after LAER	
SOP 9	Update to SOP after LAER	
Amendment to Version 11		
Section/Page Number	Detail of Amendment	Reason for amendment, if know
SOP 14	Update to SOP 14 following recommendations from Information Commissioner's Office	
Amendment to Version 12		
Detail of Amendment		Reason for amendment, if know
Update to SOP 14 following recommendations from Information Commissioner's Office		
Amendment to Version 13		
Detail of Amendment		Reason for amendment, if know
Update to local retention and destruction check list for Ninewells, PRI and Stracathro acute records to include retention of case records which have "Legal" retention sticker.		
Amendment to Version 14		
Detail of Amendment		Reason for amendment, if know
Update to SOP 19 due to change in process for requesting new or updated clinical documentation.		
Update to SOP 14 to reflect that emails should be sent to locations receiving mental health green boxes which includes sending from Ninewells and PRI. Previously SOP stated that it only related to mental health sites.		
Amendment to Version 15		
Detail of Amendment		Reason for amendment, if know
SOPs 4, 8 and 9 updated. Review of whole document undertaken.		
Amendment to Version 16		
Detail of Amendment		Reason for amendment, if know
SOP 18 updated.		
Amendment to Version 17		
Detail of Amendment		Reason for amendment, if know
Update to the procedure for the development of new/updated clinical documentation SOP in transit reporting added.		
Amendment to Version 18		
Detail of Amendment		Reason for amendment, if know
SOP 9 and 13 updated.		

SECTION 1 RETENTION AND DISPOSAL SCHEDULES

- 1.1 Introduction
- 1.2 Interpretation of Schedule: NHS Tayside Policy for main record types & local exceptions
- 1.3 Health Records Retention Schedule of all other record types
- 1.4 Resources to Support Improvement

SECTION 2 SERVICE OPERATING PROCEDURES

SECTION 1 NHS TAYSIDE : HEALTH RECORDS SERVICE Retention and Disposal Schedules

Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020

Section 6 - 'THE MANAGEMENT, RETENTION AND DISPOSAL OF PERSONAL HEALTH RECORDS

1.1 Introduction

1.1.1 Scope of Schedule

This section sets out the recommended periods for which the various personal health records created within the NHS or by predecessor bodies should be retained (in line with Principle 5 the General Data Protection Regulation), either due to their ongoing administrative value or as a result of statutory requirement. It also provides guidance on dealing with records which have ongoing research or historical value and should be selected for permanent preservation as archives and transferred to an appropriate archive.

The section provides information and advice about all personal health records commonly found within NHS organisations. The retention schedules apply to all the records concerned, irrespective of the format (e.g. paper, databases, emails, X-rays, photographs, CD- ROMs) in which they are created or held.

This section does not provide specific guidelines on determining which documents are retained as part of a personal health record. However, principles to be used in determining policy regarding the retention and storage of essential maternity records are set out. In addition, NHS organisations are reminded that good practice suggests that a policy determining which documents should remain in the record after discharge (or weeding) should be in place. The development of such a policy should include addressing any clinical requirements for completeness of information, as well as the legal requirements of the Data Protection Act 1998, which states that only personal information which is relevant and not excessive should be retained.

Whenever the schedule is used, the guidelines listed below should be followed:

- i) The recommended retention periods in this schedule must be adopted. However, local business requirements or risk analysis may require some categories of record to be kept for longer.
- ii) Recommended retention periods should be calculated from the end of the calendar year following the

last entry on the document.

iii) The provisions of the UK Data Protection Legislation Regulation and the Freedom of Information (Scotland) Act 2002 must be observed. Decisions should also be considered in the light of the need to preserve records that may be in the substantial public interest or in relation to research purposes (Section 33(3) contains some exemptions from the 5th principle of the GDPR.) This applies to records whose use cannot be anticipated fully at the present time, but which may be of value to future generations.

iv) Some classes of document must be permanently preserved and the advice of the local NHS archivist or National Records of Scotland regarding an appropriate place of deposit should be obtained.

v) The selection of records for permanent archival preservation is partly informed by precedent (the establishment of a continuity of selection) and partly by the historical context of the subject (the informed identification of a selection). It is also possible to retain a sample of certain record series. General rules should be drawn up locally, using the profile of material that has already been selected, and the history of the institution or organisation (including pioneering treatments and examples of excellence) within the context of its service to the local and wider communities.

vi) Records which, having been retained for the minimum retention period, are selected for destruction, should be destroyed appropriately, with particular regard being to whether the information contained in them is of a confidential or sensitive nature. Where deletion or destruction is not technically feasible, the records should be made permanently inaccessible to all reasonable measure e.g. deleting encryption keys for that records

Guidance on corporate (i.e. administrative, non-health) records commonly found within NHS organisations is given in [section 7](#) of the Health and Social Care Code of Practice (Scotland) 2020. These rules apply equally to the schedules contained there.

1.1.2 Responsibilities and Decision Making

For an NHS organisation to manage its records effectively, wider records management responsibilities need to be considered, placed with the appropriate individuals and/or committees, and resourced. For example, organisations may require local records managers and/or a corporate records manager; a health or medical records manager and/or committee; and an archivist.

In addition, NHS Boards are required to comply with the Information Governance standards set out in the Clinical Governance and Risk Assessment standards specified by Healthcare Improvement Scotland. These include standards applicable to administrative and patient records.

1.1.3 Retention Periods

Each organisation should produce its own retention schedule, specifying the locally agreed retention periods, in the light of its own internal requirements and those derived from the integration of Health and Social Care Services.

Organisations will need to bear in mind the need to retain records where there is any risk that they may be needed to consider/defend any legal actions. Organisations must not apply to any records a shorter retention period than the minimum set out in this schedule, but there may be circumstances in which they need to apply a longer retention period. Organisations should ensure that they are able to justify, particularly in terms of the Data Protection Act when applicable, the retention of records for longer than the minimum period set out in this schedule.

NHS Boards and GPs as producers of products and equipment, are affected by the provisions of the Consumer Protection Act 1987 covering the liability of producers for defective products. They may also be liable in certain circumstances as suppliers and users of products. An obligation for liability lasts for 10 years and within this period the Prescription and Limitation (Scotland) Act 1973, as amended by the Consumer Protection Act 1987, provides that the pursuer must commence any action within 3 years' from the date on which the pursuer was aware of the defect and aware that the damage was caused by the defect. It will be for Boards and GPs to make their own judgement in such cases on whether any health records should be retained for this minimum period in order to defend any action brought under

the Consumer Protection Act 1987. Organisations should ensure that they have mechanisms in place to identify records for which the appropriate minimum retention period has expired, in line with the 5th principle of the Data Protection Act 1998.

It is acknowledged that organizations will have different mechanisms available to them in order to do this, and that these may vary depending on the medium on which the record is held. In relation to paper records in particular, it is acknowledged that organisations may 'batch' records together e.g. on an annual basis, in order to make disposal decisions. In such instances, one approach to the calculation of minimum retention periods would be to base it on the beginning of the year after the last date on the record. For example, a file in which the first entry is in February 2001 and the last in September 2004, and for which the retention period is six years would be kept in its entirety at least until the beginning of 2011.

1.1.4 Disposal and Destruction of Personal Health Records

a. Decision Making

Staff in the operational area that ordinarily uses the records will usually be able to decide on their disposal and/or destruction. Operational managers are responsible for making sure that all records are periodically and routinely reviewed to determine what can be disposed of or destroyed in the light of local and national guidance.

In respect of personal health records, the NHSScotland Information Governance Standards require that NHS Boards establish a Patient Records Committee, which makes decisions on policy matters and which includes representation from clinical and non-clinical staff, and which is linked appropriately to other Information Governance Groups. Input from local healthcare professionals should be a key element of any records management strategy.

Once the appropriate minimum period has expired, the need to retain records further for local use should be reviewed periodically. Because of the sensitive and confidential nature of such records and the need to ensure that decisions on retention balance the interests of professional staff, including any research in which they are or may be engaged, and the resources available for storage, it is recommended that the views of the profession's local representatives should be obtained.

b. Disposal and Destruction

At the end of the relevant minimum retention period, one or more of the following listed actions will apply:

1. **Review:** records may need to be kept for longer than the minimum retention period due to ongoing administrative and/or clinical need. As part of the review, the organisation should have regard to the fifth principle of the Data Protection Act 1998, which requires that personal data is not kept longer than is necessary. If it is decided that the records should be retained for a period longer than the minimum the internal retention schedules will need to be amended accordingly and a further review date set. Otherwise, one of the following will apply:
2. **Transfer to or consult an NHS archivist or The National Records of Scotland (see 'Archives' section below):** if the records have no ongoing administrative value but have, or may have, long-term historical or research value. Organisations that do not have their own archivist should consult an NHS Archivist or the National Records of Scotland for advice.
3. **Destroy:** where the records are no longer required to be kept due to statutory requirement or administrative or clinical need, and they have no long-term historical or research value. In the case of personal health records, this should be done in consultation with clinicians in the organisation and archivists, with the necessary arrangements made to protect patient

confidentiality where appropriate. It is important that records of destruction of health records contained in this retention schedule are retained permanently. No surviving health record dated 1948 or earlier should be destroyed. Organisations should also remember that records containing personal information are subject to the Data Protection legislation.

1.2 Interpretation of the Schedule

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

- personal health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident and Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (i.e. microfiche/microfilm);
- audio and video recordings;
- emails;
- records held on computer; and
- scanned documents.

The layout and some of the content of the schedules is based on that published by the Information Governance Alliance on 20th July 2016 in its publication "Records management: code of practice for health and social care.

The Schedules are organised into a table with 3 headings:

RECORD TYPE: lists alphabetically records created as part of a particular function

RETENTION PERIOD: specifies the shortest period of time for which the particular type of record is required to be kept. This period of time is usually set either because of statutory requirement or because the record may be needed for administrative purposes during this time. If an organisation decides that it needs to keep records longer than the recommended minimum period, it can vary the period accordingly and record the decision on its own retention schedule. In this regard, however, organisations must consider data protection legislation, i.e. that personal data should not be retained longer than is necessary.

NOTE: provides further information, such as whether the record type is likely to have long-term research or historical value.

NHS Tayside will comply with the recommended retention period as laid down by the Code of Practice (see Service Operating Procedure 1). The main record types plus the local exceptions are detailed below (for all other health record types see paragraph 3):

1.3 HEALTH RECORDS RETENTION SCHEDULE – ALL RECORD TYPES

Throughout this Schedule, where the 'standard' retention period specified above applies, the relevant record type has the entry 'Retain according to the recommended minimum retention period appropriate to the patient/specialty (see above)' in the 'Recommended Retention Period' column. Where it does not apply, the required recommended retention period is listed in the 'Recommended Retention Period' column.

<i>Health Record Type</i>	<i>Recommended NHS Retention Period</i>

Adult	6 years after date of last entry or 3 years after death if earlier
All types of records relating to Children and young people (including children's and young person's Mental Health Records)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 3 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period. <i>It is recommended retaining deceased children patient records for the same period as live patients Paediatricians have requested that these are retained both considering the Child Abuse Inquiry and to enable the availability of records to assist in the treatment of siblings</i> <i>The definition of a children's records does not include CAMHS as these fall within Mental Health</i>
Mentally disordered person (within the meaning of any Mental Health Act)	20 years after date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 3 years after the death of the patient/client/service user if sooner and the patient died while in the care of the organisation. N.B.NHS organisations may wish to keep mental health records for up to 30 years before review. Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. Social services records are retained for a longer period. Where there is a joint mental health and social care record, the higher of the two retention periods should be adopted. When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review.
Records where the age and type of record cannot be determined	Where a record can no longer be read due to technology being redundant, or because the records does not contain accurate age information, or if it is considered for those records, such as tapes where the records are mixed and cannot be destroyed. Such records should be retained for 25 years since it is possible/probable that they will contain a patient who was one year at the time of the interaction.
Obstetric records, maternity records and antenatal and postnatal records	25 years after the birth of the last child or until woman reaches age 50, whichever is longer. Greater occurrence of women giving birth at more spaced periods of time until later in life.

30 years or 3 years after death	Oncology entries on other records (i.e. main acute record) should not alter the original retention period of the records, considering the regional record is kept for 30 years
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Local Exceptions:

- No surviving health record dated 1948 or earlier should be destroyed.
- Where the deceased is a child, i.e., under 16 years of age – retain for 10 years after death.
- Where there has been a diagnosis of cancer – retain for lifetime of patient.
- Where the patient has had cardiac surgery – retain for lifetime of patient.
- Where there is a retention sticker non clinical trial – retain for period specified on sticker or 3 years after death
- Where there is a retention sticker clinical trial – retain for period specified on sticker or 15 years if not specified (even after death).
- Where there is a retention sticker “Legal” – retain for period specified on sticker (even after death)

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

Reproduced below is the joint position on the retention of maternity records as agreed by the British Paediatric Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the then United Kingdom Central Council for Nursery, Midwifery and Health Visiting. This is specified in the Department of Health publication: 'Records Management: NHS Code of Practice' (270422/2/Records Management: NHS Code of Practice Part 2).

Joint Position on the Retention of Maternity Records

All essential maternity records should be retained. 'Essential' maternity records mean those records relating to the care of a mother and baby during pregnancy, labour and the puerperium. Records that should be retained are those that will, or may, be necessary for further professional use. 'Professional use' means necessary to the care to be given to the woman during her reproductive life, and/or her baby, or necessary for any investigation that may ensue under the Congenital Disabilities (Civil Liabilities) Act 1976, or any other litigation related to the care of the woman and/or her baby.

Local level decision making with administrators on behalf of the health authority must include proper professional representation when agreeing policy about essential maternity records. 'Proper professional' in this context should mean a senior medical practitioner(s) concerned in the direct clinical provision of maternity and neonatal services and a senior practising midwife. Local policy should clearly specify particular records to be retained AND include detail regarding transfer of records, and needs for the final collation of the records for storage. For example, the necessity for inclusion of community midwifery records.

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

List of Maternity Records to be retained

Maternity Records retained should include the following:

- documents recording booking data and pre-pregnancy records where appropriate;
- documentation recording subsequent antenatal visits and examinations;
- antenatal inpatient records;
- clinical test results including ultrasonic scans, alphafeto protein and chorionic villus sampling;
- blood test reports;

- all intrapartum records to include initial assessment, partograph and associated records including cardiotocographs;
- drug prescription and administration records;
- postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.

Core Recommended Retention Periods

Record Type	Recommended retention period	Notes
Adult Health Record	6 years after the date of last entry or 3 years after date of death if earlier (Scottish Prescriptions & Limitations Act.)	Refer to GP records for notes on prisoners' records being transferred to GP files.
Adult Integrated Health and Social Care Records	Longest retention period amongst regulations applicable to the partnership (e.g. IJBs) or the individual partners.	In cases where a record is held jointly by health professionals and by social care professionals the record should be retained for the longest period for that type of record, i.e. if social care has a longer retention period than health, then the record should be kept for the longer period. The SCARRS 2 Retention Schedule includes a range of timescales for different types of Adult Social Care Records. There is no single retention
Children's Health Records	Retain until the patient's 25 th birthday or 26 th if young person was 17 at conclusion of treatment or 3 years after death.	It is recommended retaining deceased children patient records for the same period as live patients. Paediatricians have requested that these are retained, both considering the Child Abuse Inquiry and to enable the availability of records to assist in the treatment of siblings.

GP Patient records MASTER PATIENT RECORD (including armed forces and prisoners)	Retain for the lifetime of the patient and for 3 years after their death.	Where the patient does not come back to the practice and the records are not transferred to a new provider, the record must be retained for 100 years. If the patient comes back within 100 years, the retention reverts to 3 years after death.
Records where the age of the patient within the records cannot be determined	Retain for 25 years from date of recording.	Where there is a lack of information in the record, or the technology is no longer available to read the record.

Specialty Records Retention Periods

Record Type	Recommended retention period	Notes
A&E Records	Retain according to core/specialty record e.g. adult/child health record	
A&E Register	8 years after the year to which they relate	
Abortion Certificates	3 years beginning with the date of termination	
Ambulance records – patient identifiable component	7 years	
Audiology records	Retain according to core record rules e.g. adult/child health record	
Breast screening x-rays	9 years from last attendance and 9 years from date of death	The Scottish Breast Screening Programme the x-rays are retained for 9 years from the last attendance and 9 years from date of death.
NHS 24 Webchat	Breathing Space 7 days all others one month.	Does not include those with police involvement, which have a retention of 6 months.

Cervical screening slides	10 years	
Child and Family guidance	Retain according to core record rules e.g. adult/child health record	
Child Protection Register	Retain according to core record rules e.g. adult/child health record	
Clinical psychology	30 years	
Contraception, sexual health, family planning and GU Medicine	adult/child health record rules if implant/device inserted 10y Family Planning: 10 years or 25 th /26 th birthday rule	GUM: Retain according to adult/child health record rules unless is an implant or device inserted, in which case is 10 years. Family Planning: 10 years after the closure of the case (25 th /26 th birthday rule for children).
Creutzfeldt–Jakob disease (CJD) records	Permanent	After the retention period should be subject to appraisal
Dental epidemiological surveys	30 years	
Dietetic and nutrition	Retain according to core record rules e.g. adult/child health record	
General Dental Services Records (Dental and auditory screening records)	Adults: 10 years Children: 10 years or up to 25 th /26 th birthday rule, whichever is longer.	
Human Fertilisation	3, 10, 30 or 50 years	Refer to section 5.14 Human Fertilisation Records. Refer to Human

Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis.	
Mental Health Records	20 years after date of last contact, or 3 years after death (except with integrated care records)	This refers to discrete mental health record types, when the patient was admitted to an acute hospital for something else that must be part of the appropriate specialty record. In the case of deaths post patients being discharged from Mental Health services, the record still must be retained based on the criteria in this schedule. Cases under Significant Adverse Event Review or with potential genetic associations should be sent for appraisal for permanent retention (recommended). (refer to useful guidance for mental health records in section 5.16)
Mentally disordered persons (within the meaning of any Mental Health Act)	Retain according to core/specialty record e.g. adult/child health record	
Midwifery records	25 years after the birth of the last child	
Neonatal screening records	25 years	
Obstetric records, maternity records and antenatal and postnatal records	25 years after the birth of the last child or until woman reaches age 50, whichever is longer.	Greater occurrence of women giving birth at more spaced periods of time until later in life.

Occupational therapy records	Retain according to core/specialty record e.g. adult/child health record	
Oncology	30 years or 3 years after death	Oncology entries in other records should not alter the original retention period of the record, considering the regional record is kept for 30 years. (refer to "Useful guidelines for Oncology records in section 5.19)
Ophthalmic records	Adults: 7 years Children: 7 years or up to 25 th birthday, whichever is longer	
Orthoptic records	Retain according to core/specialty record e.g. adult/child health record	
Physiotherapy records	Retain according to core/specialty record e.g. adult/child health record	
Podiatry	Retain according to core/specialty record e.g. adult/child health record	
Speech and language therapy records	Retain according to core/specialty record e.g. adult/child health record	
Unscheduled primary care records (patient identifiable component)	7 years	Including NHS 24 unscheduled care records, and primary care out of hours services.
Learning difficulties	Retain according to core record rules e.g. adult/child health record	
NHS 24 schedule care services	7 years	

NHS 24 Web Chat Interaction	Retain according to locally specified service specific retention period.	Retention periods for the web chat interaction record will vary depending on the specific service. The individual retention period for each service will be specified in the Board specific Retention Schedule.
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Pathology (sub-categories)

Record Type	Recommended retention period	Notes
Screening, including cervical screening, information where no cancer/illness detected is detected	10 years from creation	
Mortuary Records of deceased	10 years	
Mortuary Register	Permanent	Recommend to retain permanently and suitable for archive after 2 years.
Post Mortem Records	30 years	
Disposal of Foetal Tissue Records	8 years after the last entry	
Forensic medicine records	30 years	
Human tissue (within the meaning of the Human Tissue (Scotland Act 2006) – see Forensic Medicine	For post mortem records which from part of the Procurator Fiscal's report, approval should be sought from the Procurator Fiscal for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed.	

Births, Deaths & Adoption Records

Record Type	Recommended retention period	Notes
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Birth Notification to Child Health	25 years from receipt by Child Health Department.	Treat as a part of the child's health record if not already
Birth Registers	2 years	Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and transferred to a place of deposit (archives) at the end of this retention period.
Body Release Forms	2 years	
Death – cause of death certificate counterfoil	2 years	NHS Scotland is moving to all death certification via eMCCD.
Local Authority Adoption Record	(normally held by the local authority children's services)	<u>Refer to SCARRS: Scottish Council on Archives Records</u>
NHS Medicals for Adoption Records	Retain as for child/adult records.	

Clinical Trials & Research

For clinical trials record retention please see the

[MHRA](https://www.tsoshop.co.uk/Medical/MHRA/Good-Clinical-Practice-Guide/?TrackID-00003) <https://www.tsoshop.co.uk/Medical/MHRA/Good-Clinical-Practice-Guide/?TrackID-00003>

Record Type	Recommended retention period	Notes
Advanced Medical Therapy Research Master File	30 years after expiry date of the product or longer if required by the Clinical Trial Authorisation	See guidance Good

Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014	archive content of TMF or at least 25 years after the end of the clinical trial.	http://eur-lex.europa.eu/legislation/content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.001.01.ENG Review and consider transfer to a Place of Deposit The Clinical Trials Master File is not held by Research and Development – in general this is held by the Sponsor.
European Commission Authorisation (certificate or letter) to enable marketing and sale within the EU member states area	15 years from closure of trial	http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf Review and consider transfer to a Place of Deposit
Research data sets	As approved by PBPP (Public Benefit and Privacy Panel) on research application	https://www.jisc.ac.uk/guides/records-retention-management

Research Ethics Committee's documentation for research proposal	5 years from end of research Review and consider transfer to a Place of Deposit	For details please see: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/ Data must be held for sufficient time to allow any questions about the research to be answered. Depending on the type of research the data may not need to be kept once the purpose has expired. For example, data used for passing an academic exam may be destroyed once the exam has been passed and there is no further academic need to hold the data. For more significant research a place of deposit may be interested in holding the research. It is best practice to consider this at the outset of research and orphaned personal data can inadvertently cause a data breach.
Research Ethics Committee's minutes and papers	Before 20 years from year to which they relate Review and consider transfer to a Place of Deposit	Committee papers must be transferred to a place of deposit as a public record: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/

Cross-specialty records

Record Type	Recommended retention period	Notes
Admission books (paper)	8 years after the last entry	

Allied Health Professionals (AHP) Records	Retain according to core/specialty record e.g. adult/child health record	
Blood bank register	30 years	
Chaplaincy records	2 years	
Clinical Audit	5 years	
Clinical Diaries	2 years	It is not good practice record patient identifiable
Clinical Protocols	25 years	
Counselling records	30 years	
Destruction Certificates in relation to health records	Permanently Electronic – archival preservation in Archives.	Records of destruction of individual health records and other health records contained in this retention schedule, including Electronic records, Metadata, destruction stubs, records of clinical information held on destroyed physical media.
Discharge books (paper)	8 years after the last entry	
District nursing records	Retain according to core/specialty record e.g. adult/child health record	
Donor records	30 years post transplantation	
Genetic Records	30 years from date of last attendance	
GP temporary resident forms	Add to primary GP record (registered GP).	Copies in circulation (e.g. with PSD) to be destroyed when scanned or when registered GP confirms reception
Health Records for classified persons under medical surveillance	50 years from the date of last entry or age 75, whichever is the longer	
Health Visitor records	10 years. Children until 25 th birthday	

Homicide/Serious Untoward Incident records		Consider transfer for archival preservation
Hospital acquired infection records	6 years	
Intensive Care Unit Charts	Retain according to core/specialty record e.g. adult/child health record	
Macmillan patient records – community and acute	Retain according to core/specialty record e.g. adult/child health record	
Medical illustrations	Retain according to core/specialty record e.g. adult/child health record	
Microfilm/microfiche records relating to patient care	Retain according to core/specialty record e.g. adult/child health record	
Music therapy records	Retain according to core/specialty record e.g. adult/child health record	
Notifiable disease book	6 years	Consider for appraisal for archival preservation.
Operating theatre records	8 years after the year which they relate.	Consult with the organisation's designated archive about potential transfer for archival preservation.
Out-patient lists (paper)	2 years after the year to which they relate	
Patient held records	Refer to patient held records schedules	
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	
Photographs	Retain according to core/specialty record e.g. adult/child health record	
Private patient records admitted under section 57 of the National Health Service (Scotland) Act 1978 etc	Retain according to core/specialty record e.g. adult/child health record	

Record of long-term illness or an illness that may reoccur	Lifetime and 6 years after death	Refer to further guidelines in <u>section 5.16 Long Term Conditions (LTC)</u>
Recorded conversation which may be later needed for clinical negligence purpose	3 years from creation	
Referrals not accepted	Same as speciality/patient type of record (e.g. adult health)	
Scanned records relating to patient care	Retain according to core/specialty record e.g. adult/child health record	
School health records	Retain according to core/specialty record e.g. adult/child health record	
Smoking cessation	6 years from closure of 12 week quit period.	
Telemedicine records (clinician to patient)	Retain according to core/specialty record e.g. adult/child health record	
Transplantation records	Lifetime or 3 years after death. Transfer for permanent archival.	See guidance at https://www.hta.gov.uk/codes-practice Records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 3 years.
Ultrasound records	Retain according to core/specialty record e.g. adult/child health record	
Video records/voice/screen recordings (clinician to patient)	Same retention as main record (child/adult/specialty) Or 7 years (triage output transferred to patient record)	Where the primary purpose of the voice recording is for patient triage and the output is recorded within the patients GP record (which is then retained according to the standard minimum retention period for the patient/specialty at pages 46-47) the audio recording need only be retained for 7 years

Ward registers	2 years after the year to which they relate	
X-ray films	Refer to medical illustrations	
X-ray registers (paper)	30 years	
X-ray reports	Retain according to core/specialty record e.g. adult/child health record	

1.4 RESOURCES TO SUPPORT IMPROVEMENT

The Role of the Information Governance Framework and the Information Governance Toolkit

Information Governance is defined as:-

“A framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service”.

It is the information component of Clinical Governance and it aims to support the provision of high quality care to patients and clients and service users by promoting the effective and appropriate use of personal, sensitive information.

The Information Governance Framework enables NHS Boards and staff working within them, to ensure that personal information is dealt with legally, securely, effectively and efficiently. The focus is on setting standards and giving NHS Boards the tools to help them to incrementally achieve the defined requirements, make appropriate improvements to their service, which is sustained.

The Information Governance Framework addresses the following key areas when handling information:

- Caldicott recommendations on the use of patient identifiable information;
- NHS Scotland Confidentiality Code of Practice;
- ☐ General Data Protection Legislation
- ☐ Freedom of Information (Scotland) Act 2002;
- ☐ Information Management and Technology Security (ISO 17799 Code of Practice for Information Security Management);
- ☐ Health and Corporate Records Management;
- ☐ Information Quality Assurance.

The Information Governance Framework also enables the NHS to monitor and manage change by educating staff, developing codes of practice, helping organisations and individuals to understand the requirements of law and ethics in respect of information handling and the consequent need for changes to systems and processes. Furthermore, it enables the NHS to work in partnership with patients and clients by respecting their preferences and choices and addressing their concerns about the use of sensitive, personal information.

The Information Governance Toolkit provides the means by which NHS Boards can assess their compliance against the national information governance standards. The standards can be viewed [here](#)

The Standards in the toolkit explain and expand upon those published in the NHS QIS Clinical Governance and Risk Management Standards, which were published in October 2005. For further information please [visit here](#)

The reports produced by the toolkit will be shared with NHS QIS as part of the Clinical Governance and Risk Managements Standards peer review visits.

The Department of Health has published ‘Setting and Achieving the NHS Standards for Record Management – A Roadmap’. The roadmap applies to England only, but may be of interest to a Scottish audience as it contains a range of practical tools and guidance, including a knowledge base and templates that have been designed to support organisations in the implementation of the principles contained in the English version of the NHS Records Management Code of Practice.

The content of the Roadmap will be reviewed and updated at regular intervals. The Roadmap is available electronically to all organisations [here](#)

SECTION 2: SERVICE OPERATING PROCEDURES

Procedure Number	Operating Procedure Name
1.	Retention Destruction and Archiving of Health Records
2.	Confidentiality/Security and the Release and Management of Information
3.	Security of Health Records Storage Areas
4.	Transportation of Health Records Within and Out with Organisation Boundaries
5.	Electronic Transmission of Patient Identifiable Data
6.	Temporary and Duplicate Health Records
7.	Medical Records Filing Systems
8.	Case Record Tracking /Tracing
9.	Cannot Find & Missing Case Records
10.	Alerting Clinical Risks and Recording within Health Records
11.	Splitting of Large Health Record Folders
12.	Searching and Updating Patient Demographic Data in the Master Patient Index
13.	Handling of Subject Access Requests and associated SOPs.
14.	Filing of Loose Documentation
15.	Provision of SMRs to ISD
16.	Requesting case records for Audit purposes
17.	Recording of Advanced Directives
18.	Procedure for the development of new / updated clinical documentation

NHS Tayside Health Records Service Operating Procedure (see Section 3)

Number 1: Retention, Destruction and Archiving of Health Records

1. Opening Statement

The General Data Protection Legislation sets out a series of standards which NHS Boards and other NHS bodies must meet in order to comply with the law. One of these is that they must comply with the Fifth Data Protection Principle which is that "Personal Data processed for any purposes shall not be kept for longer than is necessary for that purpose or those purposes".

2. Retention Periods

NHS Tayside has adopted the recommended retention periods as set out in Section 1, which is derived from Section 6 of the Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020.

This document provides the retention schedule of "standard" minimum retention periods along with a further breakdown of information and advice about the retention of all personal health records commonly found within NHS organisation including :

- personal health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident and Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- x-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (i.e. microfiche/ microfilm);
- audio and video tapes, cassettes, CDROMS etc;
- emails;
- records held on computer and
- scanned documents.

Health Record Type	Minimum NHS Retention Period
Adult	6 years after date of last entry or 3 years after death if earlier
All types of records relating to Children and young people (including children's and young person's Mental Health Records)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 3 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period. <i>It is recommended retaining deceased children patient records for the same period as live patients Paediatricians have requested that these are retained both considering the Child Abuse Inquiry and to enable the availability of records to assist in the treatment of siblings</i> <i>The definition of a children's records does not include CAMHS as these fall within Mental Health</i>
Mentally disordered person	20 years after date of last contact between the patient/client/service

(within the meaning of any Mental Health Act)	user and any health/care professional employed by the mental health provider, or 3 years after the death of the patient/client/service user if sooner and the patient died while in the care of the organisation.
Records where the age and type of record cannot be determined	Where a record can no longer be read due to technology being redundant, or because the records does not contain accurate age information, or if it is considered for those records, such as tapes where the records are mixed and cannot be destroyed. Such records should be retained for 25 years since it is possible/probable that they will contain a patient who was one year at the time of the interaction.
Obstetric records, maternity records and antenatal and postnatal records	25 years after the birth of the last child or until woman reaches age 50, whichever is longer. Greater occurrence of women giving birth at more spaced periods of time until later in life.
30 years or 3 years after death	Oncology entries on other records (i.e. main acute record) should not alter the original retention period of the records, considering the regional record is kept for 30 years

3. Exceptions

No surviving health records dated **1948 or earlier** should be destroyed.

Local exceptions are:

- Where the deceased is a child, i.e., under 16 years of age – retain for 10 years after death.
- Where there has been a diagnosis of cancer – retain for lifetime of patient.
- Where the patient has had cardiac surgery – retain for lifetime of patient.
- Where there is a retention sticker – retain for period specified on sticker.
- Where there is a retention sticker non clinical trial – retain for period specified on sticker or 3 years after death
- Where there is a retention sticker clinical trial – retain for period specified on sticker or 15 years if not specified (even after death).
- Where there is a retention sticker “Legal” – retain for period specified on sticker (even after death)

4. Disposal and Destruction of Personal Health Records

Operational Managers are responsible for making sure all records are periodically and routinely reviewed to determine what can be disposed of in keeping with NHS Tayside policy.

At the end of the minimum retention period one or more of the following listed actions will apply:-

1. **Review** – records may need to be kept for longer than the recommended retention period due to ongoing administrative and or clinical need. If it is decided that the records should be retained for a period longer than the minimum, NHS Tayside retention schedules will be

amended accordingly and a further review date set. Otherwise one of the following will apply:-

2. **Transfer** - to or consult with the NHS Tayside approved archivist -Archivist, Dundee University, if the records have no ongoing administrative value but have long term historical research value,

OR

3. **Destroy** – records selected for destruction are catalogued by destruction date for future reference. Confidential destruction/disposal of health records is carried out in accordance with NHS Tayside's policy and procedures relating to Confidential Waste (see health Record Destruction Check List attached

Reference

NHSMEL (2000)17: Data Protection Act 1998 - www.sehd.scot.nhs.uk/mels/200017.doc

Records Management: Health and Social Care Code of Practice (Scotland) 2020

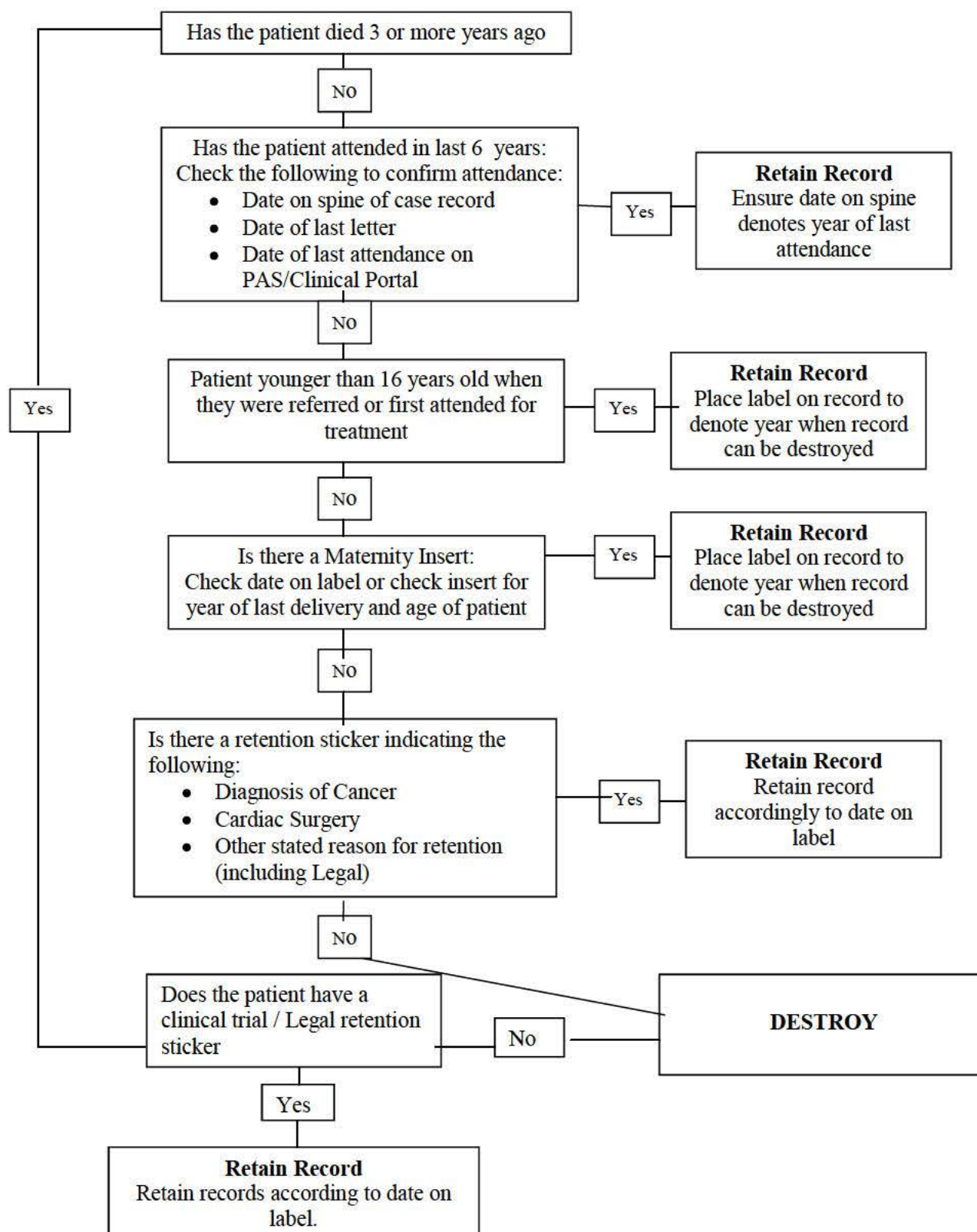
Section 6 - 'THE MANAGEMENT, RETENTION AND DISPOSAL OF PERSONAL HEALTH RECORDS

Links

Section 3 Health Records Management Policy

Service Operating Procedure 2: Confidentiality/Security and PRIMAP Standard 4 (point 4.9) - The Release and Management of Information

Health Record Destruction Check List for Ninewells, PRI & Stracathro Acute Records:



NHS Tayside Health Records Service Operating Procedure

Number 2: Confidentiality/Security and the Release and Management of Information

1. Opening Statement

Everyone working in the NHS has a legal obligation to keep all patient related information confidential.

Security and Confidentiality of data applies not only to manual health records but also computer systems both administrative and clinical, e.g. PAS, Laboratory, Radiology systems and Clinical Portal

2. Your Responsibility

Staff should read and be aware of the content of the NHS Code of Practice on protecting patient confidentiality (yellow booklet).

It is available on NHS Tayside Staffnet.

All staff must sign a confidentiality statement on commencement of duty (there is a clause in all staff contracts of employment).

Any breach of confidentiality will attract disciplinary action, which may lead to dismissal.

3. What Constitutes Confidential Data

All information held about a patient is regarded as confidential. This includes: demographic/administrative data as well as clinical data, e.g. name, address, postcode, telephone number, clinic attended, appointment details.

Health records staff should only access the information they need to carry out their duties. Staff should take care when discussing their work with colleagues e.g. not gossiping and taking care not to be overheard in public places.

4. Security

All Health Records libraries in NHS Tayside can only be accessed by staff with the proper access credentials i.e. ID badge which operates the lock mechanism.

The off-site storage facility at Claverhouse/Stracathro can only be accessed by prior arrangement with Health Records Managers.

Health Records staff will have an approved level of access to computer systems to enable them to carry out their duties.

Access to systems is by LDAP/password/user name and the password should only be known to the user. Passwords **must never** be given to or shared with other members of staff. Staff are responsible for keeping their LDAP/passwords safe/secret and up to date.

Staff must ensure they log out of systems when not in use.

Most computer systems have in-built audit trails so it is known which records have been accessed and by whom. This emphasises the need to keep passwords secret at all times.

On termination of employment the IT Department will ensure all access rights to systems is removed.

5. Staff Members with a Legitimate Right to Access Confidential Data

In order to carry out their duties many health service staff require day to day access to patient's health records or computerised data. Those staff with legitimate access include Medical, Nursing, Research, Health Records, Medico/legal, clinical effectiveness, and Allied Health Care Professionals etc.

6. General Data Protection Regulation (GDPR) / Access to Health Records Act

NHS Tayside will comply with the principles of GDPR 2018 with regard to the handling of subject access requests. The Access to Health Records Act 1990 will be complied with in regard to rights of access in relation to deceased patients only.

For full information on types of requests, timescales and costs see operating procedure 14.

7. Information Sharing

This process usually requires the consent of the patient. This may be implicit i.e., implied when the patient seeks medical care or explicit i.e., the patient makes an informed decision to consent to the release/sharing of their data.

Examples of information which may be divulged under statutory obligation include:

Notification of Infectious Diseases

Notification under child protection arrangements

Notification of Births/Deaths

Reference

GDPR 2018

Access to Health Records Act 1990

Computer Misuse Act 1990

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Procedure number 3: Security of Health Records Storage Areas

Service Operating Procedure number 14: Handling of Subject Access Requests

Caldicott Principles

"Protecting Personal Health Information" - Information Guide for Patients (Produced by ISD)

"Confidentiality - It's Your Right" (Produced by NHS Scotland)

"Confidentiality - A guide for young people under 16" (Produced by NHS Scotland)

"How to see Your Health Records") <http://www.hris.org.uk>

Policy: Local IT Security

Health Rights Information Scotland (HRIS) <http://www.hris.org.uk>

PRIMAP Standard 4 (point 4.17)

NHS Tayside Health Records Service Operating Procedure

Number 3: Security of Health Records Storage Areas

1. Opening Statement

Storage has a huge impact on the effectiveness of the service provided.

Areas must be secure to protect records against loss, damage or access by unauthorised persons.

2. Health Records Libraries

Main record storage areas should be only accessible via a swipe card system or keypad locks.

Other storage areas may be secured under lock and key.

3. Peripheral Office Accommodation and Storage Areas

Offices and other areas used to store records should be secured using lock and key, swipe card or keypad entry. Access should be available out of hours by authorised persons only. Keys for these areas should either be locally held copies (e.g. Health Records Department) or be held centrally and be signed for each time. A records inventory should be implemented for storage of records within these areas as an up-to-date health records inventory will be maintained by the Head of Health Records.

4. Off-site Storage

This area should have controlled entry ensuring that persons requiring access have to sign in and produce ID before entering

5. Electronic Storage

Access to document store is by LDAP. Control of LDAP register is with the system administration.

6. Access

All Health Records staff

Medical secretarial staff – require to sign in/out of restricted areas.

Portering/mail room staff

Estates personnel

Domestic staff

IT staff on business – required to sign in/out of restricted areas.

Clinical staff with valid reasons for access - required to sign in/out of restricted areas. Caldicott approval needed for research purposes.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Procedure number 2: Confidentiality/Security and the Release and Management of Information

Local Moving and Handling, Health & Safety, Security and Lone Working policies

PRIMAP Standard 4 (point 4.21)

NHS Tayside Health Records Service Operating Procedure
Number 4: Transportation of Health Records: Internal and External
SOP should be read in conjunction with SOP 8: Case Record Tracking)

1. Opening Statement

Patients' Health Records contain personal and sensitive information and are highly confidential documents. Care must be taken when transporting them both internally and externally to NHS Tayside.

NHS Tayside Health Records Service are responsible for the management of all records in their possession and for the preparation and dispatch of health records for onward delivery to requested locations.

When records are delivered to a service, it becomes their responsibility to maintain them.

Once a service is in receipt of Health Records, should it be deemed necessary to transfer records to another location or back to the records library, it is the responsibility of that service to arrange for the secure transfer of the records, including transport and any associated costs, if internal mail is not considered to be appropriate which should be by exception.

2. Transportation of Health Records within NHS Tayside

Health records must be securely packaged for internal transfer or carriage by internal transport service to other hospitals, clinics or offices in NHS Tayside.

Health records must be transferred using appropriately covered trolleys or cages and never be deposited and/or left unattended in areas that are not secure e.g. entrances, corridors, stairways or in vehicles where the package is visible or the vehicle unlocked. If carried by hand, records should be in a sealed envelope or blue draw string bag.

A number of handling and transportation packaging methods may be used for the secure transfer of physical health records within NHS Tayside boundaries and to partner organisations. These include:

For Transportation of Health Records within a Hospital Site

- *Purpose designed plastic boxes with seals;*
- *Brown paper envelopes;*
- *Brown paper and string;*
- *Non-tearable textured envelopes;*
- *Single record envopak carriers with seals;*
- *Multiple record envopak carriers with seals;*
- *Lockable pilot bags (for Healthcare professionals)*

For Transportation of Health Records Across Different Hospital Sites

- *Purpose designed plastic boxes with seals*

The name and exact location for delivery must be clearly marked on all packages. All internal mail containing health records or patient information should be marked "Medical – In Confidence".

Transit envelopes must not be used for internal transporting of health records and information.

Bundles of health records being collected from clinical areas in Ninewells must be securely tied in a manner which prevents patient details being visible. These records are then transported internally by Health Records Porters.

For Transportation of Mental Health Case Records within NHS Tayside (including transfer of mental health case records from Ninewells and Perth Royal Infirmary as well as all Mental Health bases)

Mental Health case records must be transported between sites using dedicated, numbered plastic boxes.

The sending location must email ahead to the receiving location, to indicate that boxes have been dispatched including the box number. The sender must also update the comments field on iFIT with the box number containing the records.

On receipt of numbered boxes, the receiving location must email confirmation back to the sender.

If the receiving location does not receive the boxes within 2 working days of the email being sent, this must be escalated to the sender, transport and support services.

If the sender does not receive an email from the receiving location within 3 working days, this must be escalated to the receiving location.

3. Transportation of Original or Copy Health Records to Hospitals or Authorised Agencies out with the Internal Mail Delivery Service

Health records for transfer by post / courier must be secured in a double envelope. The inner envelope should be brown paper and should indicate prominently “Medical – In Confidence” along with the name and address of the recipient and the name and address of the sender.

The outer envelope must be non-tearable plastic and must indicate only the name and address of the recipient. Both envelopes should be securely sealed.

If Royal Mail is used, then the Recorded Delivery Service must be employed. If any other carrier service is used, then a receipt of the transit must be obtained, including using NHS Tayside Transport Hub.

Transit envelopes must not be used for external transporting of health records and information.

4. Lifting and Handling of Health Records

See local Moving & Handling and Health & Safety policies.

5. Staff Transportation of Health Records

Staff whose roles involve transporting health records must ensure that the records are packaged securely by means of:

- *Purpose designed plastic boxes with seals;*
- *Brown paper envelopes;*
- *Brown paper and string;*
- *Non-tearable textured envelopes;*
- *Single record envopak carriers with seals;*
- *Multiple record envopak carriers with seals;*

- Lockable pilot bags (for Healthcare professionals)

If transporting health records between locations in private or NHS vehicles, the package must not be visible in the vehicle, must be transported locked in the boot and at no time can health records be left in the vehicle overnight.

Reference

Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020.

Links

Service Operating Procedure 2: Confidentiality/Security and the Release and Management of Information

Service Operating Procedure 8: Case Record Tracking

Local Moving & Handling and Health & Safety policies

PRIMAP Standard 4 (point 4.28)

NHS Tayside Health Records Service Operating Procedure

| Number 5: Electronic Transmission of Patient Identifiable Data

1. Opening Statement

Email, like other means of communication, is to be used to support NHS Tayside business.

Account holders may use e-mail to communicate informally with others in NHS Tayside so long as the communication meets professional standards of conduct. NHSmail account holders may use e-mail to communicate outside of the organisation when such communications are related to legitimate business activities and are within their job assignments or responsibilities. Account holders will not use e-mail for illegal, disruptive, unethical or unprofessional activities, or for personal gain, or for any purpose that would jeopardise the legitimate interests of NHS Tayside.

2. Use of Email to Transmit Patient Identifiable Data

Some staff may from time to time in the course of their work send patient identifiable data by email..

Staff using email to send sensitive information must ensure that the information is protected on their own system and that of the recipient. Any reports collated with patient identifiable data should also be password protected.

Some staff from time to time may work from home. Staff who fall into this category must ensure that their home 'workplace' is as secure as their normal workplace in terms of security and confidentiality. Staff working from home should be using a NHS Tayside laptop which is finger printed and password protected.

Generic Mail boxes are used to receive patient identifiable information – such as referrals from locations which do not have access to SCI-Gateway and notification of deaths to the Access team. Only appropriate staff have access to the generic mail boxes. The mail boxes should be checked daily, with the agreed criteria checked and a reply sent confirming receipt, where appropriate.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Procedure 1: Confidentiality/Security and the Release and Management of Information

Service Operating Procedure 16: Registration of Patient Referrals on Patient Administration System

PRIMAP standard 4 (point 4.31)

NHS Tayside e-Health Strategy

NHS Tayside Referral Management System

NHS Tayside-Use of Email and Network Services Policy

NHS Tayside Use of Portable Computers and Removable Data Policy

NHS Tayside Health Records Service Operating Procedure

Number 6: Temporary and Duplicate Health Records

1. Opening Statement

A temporary case record folder may only be issued on the instruction of a member of the management team when she/he is satisfied that an exhaustive search has been carried out and original case record cannot be found having followed all steps in SOP 9 (Cannot Find & Missing Health Records)

When duplicate registrations are identified action must be taken to amalgamate both physical case record and computerised system.

2. Procedure for Issuing Temporary Case record Folder

Senior Health Records staff (team leader) can authorise the creation of a duplicate or temporary case note folder. This should only be done after an exhaustive search for the original records as per SOP 9.

If other appropriate locality Health Records exists then a Temporary folder should not be raised. In this case iFIT should be marked that the other locality records are to be used.

All relevant correspondence should be sourced from, electronic systems, e.g. Central Vision, Document Store, secretarial staff and general practitioners.

Orange casenote folders are available to use as Temporary files.

3. Amalgamation of Documentation

When original case note folder is located then this should be checked with the temporary to ensure that the original is complete.

Duplicate information should be destroyed confidentially.

4. Tracking of Temporary Case records

Temporary case notes should be raised on iFIT and tracked. These should be marked as destroyed if the original record is found.

5. Amalgamation of Duplicate Registrations/Case records

Where duplicate registrations occur, this is usually due to erroneous new registrations or if the patient has two registrations covering different board areas. The correct number should be ascertained completing Duplicate Registration form or following advice from CHI Administrator.

When a duplicate registration, electronic systems should be updated by merging the wrong number with the correct number.

Case notes should be amended to reflect the current number and any incorrect labels destroyed

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Procedure number 2: Confidentiality/Security and the Release of Management Information

Service Operating Procedure number 8: Case Record Tracking/Tracing

Service Operating Procedure number 9: Missing Case Records

PRIMAP Standard 4 (point 4.38)

NHS Tayside Health Records Service Operating Procedure

Number 7: Medical Records Filing Systems

1. Opening Statement

The prime purpose of a Health Records Department is to bring together 3 key players, the patient, the doctor/healthcare professional and the case record i.e., have the right case records in the right place at the right time.

Whichever filing system is used, it is imperative that case records are filed accurately as a great deal of time can be wasted searching for mis-filed records.

Failure to produce the case record may result in:

- past medical history being unavailable;
- refusal/delay by Consultant to see patient;
- cancellation of procedure;
- distress to patient/relative;
- increase in clinical risk.

2. Filing System

NHS Tayside complies with national requirements by using the unique patient identifier i.e. CHI (Community Health Index) number to register health records and manage patient records for storage and retrieval purposes. The CHI number is a unique numeric identifier, allocated to each patient on first registration with the system. It is a 10 – character code consisting of the 6 – digit date of birth (DD/MM/YY), 2 digits, a 9th digit, which is always even for females and odd for males, and an arithmetical check digit. CHI contains details of all Scottish residents registered with a general practitioner. It is a key component in the implementation of Electronic Patient Record.

For management and retrieval purposes NHS Tayside uses iFIT which is an advanced case records tracking system (see SOP 8). Case Records have an iFIT barcode which identifies the record by using the patient's CHI and also the case record type and volume number. All Acute libraries in NHS Tayside file by iFIT location based filing. Mental health libraries have a mixed economy of iFIT location based filing and CHI filing as does Claverhouse. Dundee Dental Hospital file in CHI order.

3. Case records Storage Systems

The main health record libraries within NHS Tayside for **acute medical record services** are located at:

- Ninewells, Perth Royal Infirmary, Stracathro Hospital and Claverhouse

The main health record libraries within NHS Tayside for **mental health record services** are located at;

- Carseview Centre, Murray Royal Hospital and Stracathro Hospital;
- Mental health records for children and adolescent patients are held within the library at Centre for Child Health in Dundee;

Tayside Psychological Therapy Services retain patient records at Dudhope Terrace for Dundee records, Murray Royal Hospital for Perth records and Stracathro for Angus records. Non active Dundee psychological therapy case records are stored at Carseview.

The main health record library within NHS Tayside for **dental health record service** is at Dundee Dental Hospital. Dundee Dental Hospital archived health records are scanned into the Document Management Store.

Definition of Terms & Acronyms

Health Record – the health record is a single record with a unique identifier, which is a composite of all data on a given patient. It contains information relating to the physical or mental health of an individual 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 individual. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the on-going care of the patient to whom it refers.

Reference

Standard BS.5454:2000

Standard ISO 15489

Links

Service Operating Procedure 1: Retention, Disposal and Archiving of Health Records

Service Operating Procedure 2: Confidentiality/Security and the Release and Management of Information

Service Operating Procedure 3: Security of Health Records Storage Areas

Service Operating Procedure 4: Transportation of Health Records (Local Moving & Handling policy)

PRIMAP Standard 2 (point 2.27)

PRIMAP Standard 4 (point 4.21)

NHS Tayside Health Records Service Operating Procedure

Number 8: Case record Tracking

1. Opening Statement

When health records are removed from the filing system or given from one person to another the case record tracking system (iFIT) must be updated with the case records new location e.g. clinic ward of admission, clinician's office etc. Failure to update the tracer card or tracking system as case records are removed from file or change location may result in case records not being available when required.

2. General Principle

When a case record is required to be removed from any records library e.g. admission/out patient attendance/other reason the case notes new location must be entered in to iFIT by health records staff. The following information must be recorded:

- date/clinic/ or ward or office etc.

When the notes are received at the new location the recipient e.g. out patient receptionist/medical secretary/ward clerk is responsible for recording receipt of the case records either by confirming receipt in the tracking system. If the records are subsequently passed to a new location then the new location must be updated by the sender with the new location.

3. Process for Confirming Case records Back into File

When case notes are to be returned to the health records library the sender must record this in the tracking system (iFIT).

On receipt at the records library health records staff will track and file them back into the location based filing using mobile devices. In libraries that file by CHI the records should be placed in the correct place on the shelf.

4. Computer System Downtime

In the event of computer system downtime and the tracking system cannot be updated, staff in all areas must compile a list of case note movements utilising the bar code/patient labels in the case records recording the date/time and destination of case records. When the system has been reinstated the tracking system must be updated immediately by all senders/recipients of case records. When the system has been reinstated the tracking system must be updated immediately by all senders/recipients of case records. When the system has been reinstated the tracking system must be updated immediately by all senders/recipients of case records.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Policy 4: Transportation of Health Records within and outwith Organisation Boundaries

Service Operating Policy 7: Medical Records Filing Systems

PRIMAP Standards 2 (point 2.28) and 3 (point 3.11)

iFIT Case Note Tracking System User Guide

NHS Tayside Health Records Service Operating Procedure

Number 9: Cannot Find & Missing Case Records

1. Opening Statement

Health Records staff are responsible for ensuring that all patients' case records that are held within the Health Records Libraries are available for any attendance or admission that the patient may have at hospital. Health Records will request any records that are with other services/departments via iFIT and it will be the responsibility of the holder of the record to ensure they are available for the attendance. In addition to this, case records require to be obtained timeously for a number of administrative processes.

2. 'Cannot Find' Records

- If Health Records staff identify that Records are not in the location that they are tracked to they should mark them as Cannot Find
- If a Service or Department identify that they are unable to locate a set of records that are tracked to their location they should notify Health Records who will mark the record as Cannot Find

3. Procedure for Locating Cannot Find Records

If case records are not in the location they are tracked to then checks should be instigated to review the previous history of case note movements and last few locations. Use information on iFIT tracking system (including sensor movements).

If records are RFID tagged, upload to RFID gun and scan library and/or other areas where case records may be. Routine searches of all library areas should be carried out on a daily/weekly basis using the RFID guns. Other wards/departments should be searched as and when required.

For CHI based filing:

- Check the shelf where the record belongs (i.e. day/month of birth 01/01)
- Check shelves immediately above and below
- Check next/previous day of birth

4. Management of 'Cannot Finds'

Weekly reports of the number of records that have been marked as 'Cannot Find' for more than 2 weeks are produced from iFIT and circulated to the Health Records Management Team. Manager of the Health Records library where the records were created will raise a Datix, using the following categories:

Event category – Documentation/Administration

Subcategory – Missing Medical Records

Other people involved in event – contact for the location where records last located

Information Governance will review all Datix's raised under 'Missing Records' subcategory and a decision will be made whether to contact the Information Commissioner's Office and the patient.

The service/department that the record was last tracked to should be informed that a Datix has been raised and that they are required to thoroughly search their own area for the records using all available methods (RFID guns/manual search/shelf audits).

When records have been marked as 'Cannot Find' for 1 month or more, they will be discussed at a monthly Cannot Find/In Transit meeting. This meeting is attended by all Library managers, Locality managers and the Head of Health Records. The group assign further actions/searches to be undertaken and agree escalation to the Head of Service where the records were last located. The Datix should be then be updated.

If records have been marked as 'Cannot Find' for 3 months they should then be marked on iFIT as being 'Missing' and the Datix updated.

The number of Cannot Finds and Missing case records are reported at the Health Records Operational Management Meeting on a monthly basis and the Health Records Committee on a quarterly basis.

5. Temporary Case Records

Temporary case notes should be raised on iFIT whenever it is appropriate, and tracked. These should be marked as destroyed if the original record is found.

6. Amalgamation of Documentation

When the original case note folder is located then this should be checked with the temporary to ensure that the original is complete. Duplicate information should be destroyed confidentially.

Reference

Records Management: NHS Code of Practice (Scotland) 2012

Links

Service Operating procedure number 6: Temporary and Duplicate Case Records

NHS Tayside Health Records Service Operating Procedure**Number 10: Highlighting Clinical Trials/Alerts/Risks and Recording within Paper Case Records****1. Opening Statement**

To help ensure that patient care is delivered as safely as possible all case note folders shall have an appropriate space for the recording of clinical alerts/risks. These can be defined as e.g.:-

- Allergies
- Risk factors when dealing with an individual patient
- Participation within a clinical trial

2. Procedure

The front cover of the case note folder should be appropriately highlighted with e.g., a tick in the alert box. The full details of the trial/alert/risk are recorded on the inside cover, on the clinical trial insert or in the appropriate space on the Abstract Sheet.

All entries must be dated and signed by the health professional noting the trial/alert/risk.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

PRIMAP standard 3 (point 3.4)

NHS Tayside Health Records Service Operating Procedure

Number 11: Splitting of Large Health Record Folders

1. Opening Statement

When the documentation relating to a patient can no longer be securely filed in one volume, a second volume is created to hold the overflow. Some patients may require a third or fourth volume in order to keep the health record manageable.

2. Numbering

NHS Tayside records libraries split health records with large volumes of documents by creating a second and often further volumes of records. Historically, these additional volumes have been subject to different numbering procedures relating to the different locality health records libraries. For example, new folders created as a result of splitting health records may be marked as Volume 2, or File B, or Folder 1 of 2. Consistency within each library ensures best practice.

3. Procedure for Splitting Health records

Whilst local practice may vary (see paragraph 4 below) the following essential aspects of splitting health records will be adhered to:-

- It is essential that health records are split either at the end of an episode of care or at a convenient point in time e.g., end of a Month/Year;
- NHS Tayside's health Records Committee has given authorisation that lab results/ lab results mount sheets and multi-disciplinary/nursing records can be stored in a closed volume. This volume should be marked up as per local practice (see paragraph 4 below).
- Any additional volumes created should be recorded on iFIT.
- Second volume will be dated with creation date visible on front cover and in the case of mental health case records noted on internal abstract sheet;
- Closure date of first volume will be recorded and visible on front cover and noted on internal abstract sheet;
- Retention periods will be applied to all volumes of health records.

4. Local Medical Record Library Practice

Acute Hospital Case Notes

Ninewells Hospital

1. The new volume will hold the current specialty in which the patient is being seen e.g. if a patient was referred to an ENT clinic and the record required to be split the ENT divider and documentation would be put into a new volume at the pre registration process with the previous records remaining in the old volume.
2. The old volume is marked as Volume 1 of 2 and the new volume marked as 2 of 2.
3. Health Records staff may go down to wards to split folders with the current specialty being filed in the new volume
4. The case record marked as e.g. volume 2 of 2 hold the most up to date information.

Perth Royal Infirmary

1. The new volume will be marked as Folder 1 of 2 and the old one as 2 of 2. Folder 1 holds the most up to date information.
2. The new folder will hold the most up to date correspondence e.g. from 2008 onwards. The old folder will be marked as holding older correspondence e.g. 1996-2007.
3. The most recent nursing notes will be stored in the closed volume (i.e. volume 2 or greater).

Stracathro Hospital

1. Case records are checked before leaving and on return the records library.
2. A new volume will be created, if required, containing the most up to date information.
3. The case record marked as e.g. volume 2 of 2 holds the most current information.

Mental Health Case Records

1. Case records are sent to the medical records department when another volume is required.
2. The case record is then split at an appropriate place e.g. before or after an admission or in the case of a long term patient, at the end of a year.
3. Record the date closed on the folder and mark it as volume 1
4. Generate a new folder and tracer card, mark the folder with the date it was opened and also mark as volume 2.
5. Tracer cards will also be marked with the correct volume number and the dates volumes were opened/closed.
6. The case record folder with the highest number holds the most up to date information.
7. **Mental Health Stracathro** – Long Term Psychiatry of Old Age records are split by divider rather than date.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links:

Service Operating Procedure 1: Retention, Destruction and Archiving of Health Records

Service Operating Procedure 7: Medical Records Filing Systems

Service Operating Procedure 8: Health record Tracking/Tracing

PRIMAP Standard 3 (point 3.10)

marked on the external cover of the record. When these are returned to the library, the records should be recorded to the deceased file. Care should be taken that the date of death is also recorded on TrakCare

NHS Tayside Health Records Service Operating Procedure

Number 12: Searching and Updating Patient Demographic Data in the Master Patient Index (MPI)

1. Opening Statement

The Master Patient Index is an alphabetical key to records which are filed numerically. It allows patient search, amendment to patient demographics and registration of new patients creating a departmental patient identification number which is linked to the Community Health Index number as the unique patient identifier. It can be kept on a computerised patient administration system (PAS) or on a manual card system.

The electronic system with an MPI currently in use within NHS Tayside is known as TrakCare.

2. Information Held on Master Patient Index

The following demographic information is held on the MPI:

- CHI number
- date of birth
- name
- address and postcode
- temporary address and postcode
- home, work and mobile telephone numbers
- health board of residence
- general medical practitioner/general dental practitioner
- next of kin
- ethnicity
- religion
- date and place of death
- demographic history

3. Search and Registration Techniques

To help trace previously registered patients in TrakCare the following search fields are available:

- surname
- forename
- date of birth
- CHI number

A search can be completed to trace the correct patient by using a single field or combination of fields, e.g. date of birth or name and date of birth.

Authorised Health Records staff have access to CHI24 (National CHI) which allows the registration of new patients not previously registered in Scotland. These patients are allocated their CHI number and their demographic information is subsequently available to be downloaded to TrakCare via the SCI search feature.

Also for patients already registered on the national CHI a search can be completed in SCI store in TrakCare for patients not previously registered in Tayside. If the correct patient is traced then the patient's demographic information can be downloaded to TrakCare via the SCI search feature.

4. Maintenance of Master Patient Index

All patient demographic information is recorded, updated and saved in the MPI.

The recording/updating of this information is the responsibility of the medical records department and can be done either on the receipt of an out patient referral letter or on the admission of a patient to hospital or at out patient reception desk.

The recording of patients' deaths in the MPI is done by way of one of the following:

- recorded by ward staff in bed management system.
- notification forms sent by wards/departments to medical records department or by message left on out of hours answer phone..
- notification received by medical records department from Registrar General's Office or from the patient's general medical practitioner.

5. Unknown Patients

If a patient attends the Emergency Department and is unable to provide their demographic information ED Reception staff will register the unknown patient on the Community Health Index with a date of birth as that day's date (day and month) and a estimate of the patient's year of birth. The patient's name would be recorded as 'unknown male or female' and address recorded as unknown. Staff would then generate a CHI for the patient. Once the demographic information has been established ED/Health Records would update CHI and Trak accordingly.

If a patient is admitted directly to a ward and is unable to provide demographic information, the ward must inform the Health Records Department of the patient's arrival. Health Records staff will register the unknown patient on the Community Health Index with a date of birth as that day's date (day and month) and a estimate of the patient's year of birth. The patient's name would be recorded as 'unknown male or female' and address recorded as unknown. Staff would then generate a case record for the patient. Once the demographic information has been established the ward shall inform Health Records who will update all systems and case records accordingly.

6. Data Quality

The following fields are mandatory within the MPI:

- date of birth
- title
- forename
- surname
- address
- ethnicity
- general practitioner
-

In the event of a duplicate patient registration being notified to the medical records department or discovered during work processes the MPI records will be merged within PAS with the confirmed registration (CHI number) on CHI being adopted as the correct number for use. If there are two sets of case records for the patient then these shall also be merged using the correct CHI number.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

Service Operating Procedure number 6: Temporary and Duplicate Health Records

PRIMAP standard 4 (points 4.10 and 4.12)

NHS Tayside Health Records Service Operating Procedure Number 13: Monitoring In-Transit Records

1. Opening Statement

When records leave a location to be returned to a Health Records library, they should be tracked on iFIT as 'In-Transit to the specific records library'. In order to identify any records which have not arrived at their destination, or have not been tracked back into the records library, the procedure below should be followed on a weekly basis.

2. Procedure to Identify 'In-Transits'

The manager of each library should run iFIT report 'no of health records outside libraries' on a weekly basis and select the appropriate local library location:

- NW.MR
- PR.MR.AC
- ST.MR
- MR.MR
- CV.FR
- SRH.MR

Export the report to MS Excel, filter to identify records that have been in-transit for more than 1 week and save to a shared folder.

These weekly reports should be emailed to the Health Records Locality Manager at the end of each month.

3. Management of 'In- Transits'

If there are records showing on the report, contact the sending department to confirm that the records were sent and on what date/time.

If it is confirmed the records were sent, contact Transport and Logistics to check if there have any delivery delays. If no delays confirmed, use iFIT RFID tracking devices and manual search techniques to try to locate the records.

If the records cannot be located within 2 weeks, a Datix should be raised by the sending department and the Head of Health Records informed.

The iFIT status should be updated to 'Cannot Find' and the process for these records then followed.

Links:

Service Operating Procedure 4: Transportation of Health Records: Internal and External
Service Operating Procedure 8: Case Record Tracking
Service Operating Procedure 9: Cannot Find & Missing Case Records

NHS TAYSIDE**HEALTH RECORDS SERVICE OPERATING PROCEDURE
NUMBER 14: HANDLING OF SUBJECT ACCESS REQUESTS****Opening Statement**

NHS Tayside will comply with the principles of the General Data Protection Regulation (2018) with regard to the handling of subject access requests. The Access to Health Care Records Act 1990 will be complied with in regard to rights of access in relation to deceased patients only.

A Background to the Regulation/Act

The Regulation/Act gives patients or their representatives the right of access, subject to certain exemptions [see D and E below], to most health records containing information about themselves, relatives, etc. Access can be restricted in specified circumstances and then only to the sensitive part of the record.

B Right of Access

The following people have right of access:-

1. The patient.
2. A person authorised in writing, to apply on behalf of the patient e.g. relative, solicitor, insurance company.
3. Where the patient is a pupil, the parent or guardian.
4. Any person appointed by the court to manage the affairs of a patient who is deemed to be incapable.
5. Where a patient has died, the patient's representative, or any person having a legal claim arising from the death.

C Application

If a patient asked to see their health record during a consultation or treatment, and this is practical, the Clinician should co-operate. This may include arranging a mutually suitable time at a later date. If it is not possible to agree at that time, or if a patient decides later to request access, the application should be made in writing.

D Whole or Partial Exemptions

Cases where access may be wholly excluded:

1. Access shall not be given unless the holder of the record is satisfied that the patient is capable of understanding the nature of the application.
2. Where the applicant is the parent or guardian of the patient who is a pupil, access should not be given unless the holder of the record is satisfied that the patient has consented to application or that the patient is capable of understanding the nature of the application and the giving of access would be in his/her best interests.
3. Where the patient has died and the record included a note made at the patient's request that he/she did not wish access to be given to his/her personal representatives, or to any person having a legal claim arising from the patient's death.

E Cases where Partial Access may be Extended

Where in the opinion of the holder of the record the information may cause serious harm to the physical or mental health of the patient, or other individual.

Where information provided by a third party, who would be identified from their information. You do not have to have to disclose information about another individual who can be identified from the information, except if:

- The other individual has consented to the disclosure; or
- It is reasonable to comply with the request without that individual's consent

And in determining whether it is reasonable to disclose the information, you must take into account all the relevant circumstances, including:

- The type of information that you would disclose;
- Any duty of confidentiality you owe to the other individual;
- Any steps you have taken to see consent from the other individual;
- Whether the other individual is capable of giving consent; and
- Any express refusal of consent by the other individual.

Where an application is on behalf of a child or pupil, or where the patient is incapable of managing his/her own affairs, or where a patient has died, access may be refused to that part of information provided by the patient, in the expectation that it should not be disclosed to the applicant, or where information was obtained as a result of examinations to which the patient consented in the expectation that the information would not be disclosed.

Where a patient has died access shall not be given to any part of the record, which in the opinion of the record holder, would disclose information which is not relevant to any legal claim which may arise out of the patient's death.

The whole, or part exemptions are the only circumstances in which access may be limited or excluded.

In Mental Health case records there is a specific divider for 3rd Party Information behind which all 3rd Party Information should be filed.

Definitions as per the Regulation/Act

The Application – an application in writing.

Health Record – the Health Record, both paper and electronic and related expressions, are defined as being information relating to the physical or mental health of an individual who can be identified from that information, and which has been made by or on behalf of a health care professional, in connection with the care of that individual.

The Holder of the Health Care Record – is defined as being NHS Tayside or any other health care professional by whom, or on whose behalf, the record is held.

The Health Professional – the Health Professional is e.g.:

- A registered Medical Practitioner
- A registered Dentist
- A registered Pharmaceutical Chemist
- A registered Nurse, Midwife or Health Visitor
- A registered Chiropodist, Dietician, Speech Therapist, Occupational Therapist, Orthotist , Orthoptist, Physiotherapist or Prosthetist
- A Clinical Psychologist, a Child Psychologist
- An Art and Music Therapist engaged by the Board
- A Scientist engaged by NHS Tayside as Head of the Department

G Administrative Procedure

Where the patient or their representative wish to apply for access to their Health Care Records they shall be referred to the Records Manager or Practice Manager who will be responsible for the overseeing of the provision of access. There may be a fee for access if the request is unfounded or excessive, particularly if it is repetitive. Any charges will be notified in writing to the applicant during the access process and must be settled before access is arranged or any copies released.

Where it becomes clear during the access process that the application is related to a potential negligence claim against the Board, the access process will cease immediately and advice sought from the Board's Legal Claims Manager. The access process may re-start but only on the advice of the Legal Claims Manager.

H PROCEDURE FOR HEALTHCARE PROFESSIONALS, GP PRACTICE MANAGERS AND RECORDS MANAGERS

The following procedure should be followed when written or verbal requests for access to records are received.

1. Facilitate access during consultation or treatment, if appropriate.
2. Advise the patient or their representative that there is a requirement to complete an Application for Access to Health Records form, which will contain the vitally important details to enable checks to be carried out to ensure that the correct record is found. The patient should be advised of the response time to complete the request.
3. On receipt of the completed application form the Records Manager or GP Practice Manager will:-
 1. Check that the application form has been completed correctly by the applicant or by the representative of the applicant and start the subject access check lists.
 2. Obtain the health record and refer to the appropriate health care professional for advice. If the information is "old information" and the health care professional is no longer available, the application should be referred to the appropriate Lead Clinician or Medical Director, or Head of Practice for GP Records.
4. The health care professional will, on receipt of the request for access to health records:-
 1. Advise the Records Manager or GP Practice Manager on the access which would be denied, ensuring that he has sought the views of other health professionals who had had a significant input into the patient's care.

The health care professional should:-

2. Decide whether to allow the patient to inspect the record (including the issuing of copy records).
3. Decide if the patient may only see an extract, and if so, prepare the extract to be given to the patient.
4. Advise the Records Manager or GP Practice Manager whether options (i) or (ii) are to be applied.
5. Advise whether or not he considers he should be present when the patient is to inspect or receive the health record in order to provide explanations or counselling to the patient or patient's representative.
6. Where the patient referred to is deceased, advise whether access to any part of the record preceding 1st November 1991 should be allowed in order to make intelligible any part of the Record to which access will be given under the Act.

The applicant has the right to have his request completed within 31 days of receipt of completed Application for Access to Health Records form.

I Provision of Copy Records

The Records Manager or GP Practice Manager will be responsible for ensuring that any

photocopies required by the applicant are provided.

J Other Subject Access Requests

Other Subject Access Requests include:-

- Court Orders
- Procurator Fiscal
- Police enquiries*
- Criminal Injuries Compensation Board
- Department of Work and Pensions enquiries
- Medical Reports
- Compensation Recovery Unit

All the above are dealt with and processed by the Health Records Department and, where appropriate, within agreed time scales e.g. within 7 days for a court order and if appropriate with the relevant Health Professional. If the request is from an outside agency, other than those listed above then the request should be escalated to the Health Records Manager for advice and further escalation if required.

If there is a potential claim/complaint then the request should be escalated to the Complaints Department.

* The sharing of information with Tayside Police is governed by the Sharing Information with the Police – Arrangements and Guidance Protocol agreed between NHS Tayside and Tayside Police, further information on this protocol is available from the Information Governance Officer.

K Complaints

If the health care professional, GP, Records Manager or Practice Manager are advised by the applicant that they do not think NHS Tayside has complied with the Regulation/Act, the applicant should be advised to contact the Complaints and Advice team.

Reference

- Access to Health Records Act 1990
- General Data Protection Regulation (2018)
- Records Management:NHS Code of Practice (Scotland)
- Caldicott Principles

Links

- Service Operating Procedure number 2:Confidentiality/Security and the Release and Management of Information
- PRIMAP Standard 4 (point 4.18)

STANDARD OPERATING PROCEDURE

DEPARTMENT OF WORK AND PENSIONS (DWP) DISABILITY FORM SOCIAL SECURITY FORM COMPENSATION RECOVERY UNIT (CRU)

Department of Work and Pensions (DWP) Disability Form

Log request on spreadsheet on SAR shared drive.

Check on TrakCare that the patient has been treated by the doctor whose name is on the form.

Check TrakCare - Enquiry
 - Inpatient episodes
 - Out-Patient appointments

Then locate the patient's case records.

Track them out to "secretary name/consultant name Disability Form".

Photocopy the part of the form showing the patient and consultant's name.

Add a note to show the date the form and case records were sent to the consultant and file it in the appropriate folder.

Send the records and the original form to the relevant secretary.

Social Security Form

Use TrakCare to find out the patient's date of birth and CHI number and then use the system details to complete the form and then return it to the enquirer in the pre-paid envelope.

Compensation Recovery Unit Forms

Check the Compensation Recovery Unit System for these on a daily basis. They are distributed electronically via a UK-wide government agency. They allow NHS Tayside to recover costs of treating victims of road accidents from the motor insurance companies.

1. Check the Compensation Recovery Unit System for patient information.
2. Check TrakCare for in-patient episodes on or after the date provided.. If there are episodes then check the patient's records to see if these were due to the accident. If they are, complete the on line form.
3. If there are no in-patient episodes, check TrakCare and CRIS for episodes relating to the accident. Check that the attendance was because of the accident and that the patient was sent home afterwards. Check also with x-ray and Physiotherapy. If you find details, enter them on the Compensation Recovery System .

STANDARD OPERATING PROCEDURE**CRIMINAL INJURIES COMPENSATION AUTHORITY (C.I.C.A.)**

If the request is from the Criminal Injuries Compensation Authority for a medical report:-

1. Open up SAR spreadsheet
2. Date stamp request letter.
3. Check TrakCare for records.
4. If there are no records, request casualty slips (Doc.K),
5. Identify Consultant from casualty slip.
6. Send Doc.K to Consultant/Doctor + reply envelope.
7. If no records, return form to C.I.C.A. (Doc.L).

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY
 Telephone Number: (01382) 660111
 Fax Number: (01382) 632349
 www.nhstayside.scot.nhs.uk

(Recipient's Name)
 Address 1
 Address 2
 Address 3
 Address 4

Date
 Your Ref
 Our Ref

 Enquiries
 to
 Extension
 Direct Line
 Email

Dear

Patient Name and CHI

I enclose herewith a letter from CICA, requesting a medical report on the above named patient.

I would be obliged if you could prepare a report and forward it in the attached envelope. If you are unwilling to prepare a report, or if you feel the request should be passed to a colleague, please advise this office as soon as possible.

Medico-legal reports no longer require to be checked by the Central Legal Office unless you feel there may be any prejudice to the NHS Tayside or to colleagues, and you should advise me if you require this particular report to be checked.

I look forward to receiving your report.

Yours sincerely

Authorising Signature

Enc: Form
 Envelope

N.B. Please return in the envelope provided. Thank you.

Doc.K

Health Records Department
Level 7
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: (01382) 660111
Fax Number: (01382) 632349
www.nhstayside.scot.nhs.uk

C.I.C.A.
Tay House
300 Bath Street
GLASGOW
G2 4JR

Date
Your Ref
Our Ref

Enquiries
to
Extension
Direct Line
Email

Dear Sirs

Patient Name and CHI

I refer to your letter in connection with the above named, which I now return.

Unfortunately no trace can be found of an attendance at (name of Hospital), **on the incident date provided.**

If you can provide any further information that may assist, please do not hesitate to contact this office.

This patient's G.P. may hold relevant records.

I would advise you that abuse/rape/psychiatric cases would not have medical records within the normal case note folder. If this patient falls within any of these categories, it may be helpful for you to contact the General Practitioner or the appropriate Police Division.

Yours faithfully

Authorised Signature
Enc:

Doc.L

STANDARD OPERATING PROCEDURE

PROCEDURE FOR PROCESSING APPLICATIONS FOR ACCESS TO HEALTH CARE RECORDS FROM SOLICITORS/INSURANCE COMPANIES

The following procedure should be followed when requests for access to health records are received from legal representatives/insurance companies.

On receipt of a request and signed mandate from the patient, or patient's representative for a child or deceased person, take the following actions:-

1. Log request on spreadsheet on SAR shared drive.
2. Any request from a solicitor should be accompanied by a signed mandate from the patient. If the solicitor is requesting copies of the full record, then the mandate should state this. If the mandate signed by the patient does not state that full record may be copied, then the solicitor should be contacted and advised that they need to provide a mandate signed for the release of the full record or otherwise give details of what specialties and dates are required to be copied for the request.
3. Complete Permission Slip (Doc.M), attach to letter and send to Consultant with casenotes. Also, send out Acknowledgement Receipt.
4. Await return of permission slip, etc.
5. If any records or x-rays are held outwith the main health records, e.g., child health, speech and language therapy and physiotherapy a copy of the original request and mandate (along with Doc.N) should be sent to the appropriate lead person to action the request within the same time-scales as the clinician, i.e., 5 working days. These copies should be returned to the Access Team Office to be sent out as a completed request.

Any requests for x-rays should be forwarded to the Radiology Department along with completed request form (Doc X).

6. If not returned within 10 days, begin chase-up process.
7. If, at any stage of the process, there is likely to be a breach of the time-scales, the Health Records Manager must be informed immediately.
8. Charge Admin. Fee if appropriate (Doc.O).
9. Copy Requested records and follow procedure noted below.
10. Place permission slip in folder.

Records for Independent Expert (Production of report by Expert for Solicitor/Agent)

Requests received from Consultants outwith NHS Tayside should be dealt with by photocopying the Health records, gathering x-rays (if any) (Ext. **CATE**) and sending letter Doc.O to the Solicitors/Insurance Company.

REQUEST FOR MEDICAL RECORDS PERMISSION SLIP

Date:.....

To:-

We have received this request from the patient's Solicitors/Agent. We require your response within 5 working days in order that we can comply with governed time-scales.

Please note that there may be cases where partial access may be extended including:

Where in the opinion of the holder of the record the information may cause serious harm to the physical or mental health of the patient, or other individual.

Where information provided by a third party, who would be identified from their information. You do not have to have to disclose information about another individual who can be identified from the information, except if:

- ***The other individual has consented to the disclosure; or***
- ***It is reasonable to comply with the request without that individual's consent***

And in determining whether it is reasonable to disclose the information, you must take into account all the relevant circumstances, including:

- ***The type of information that you would disclose;***
- ***Any duty of confidentiality you owe to the other individual;***
- ***Any steps you have taken to see consent from the other individual;***
- ***Whether the other individual is capable of giving consent; and***
- ***Any express refusal of consent by the other individual.***

Where an application is on behalf of a child or pupil, or where the patient is incapable of managing his/her own affairs, or where a patient has died, access may be refused to that part of information provided by the patient, in the expectation that it should not be disclosed to the applicant, or where information was obtained as a result of examinations to which the patient consented in the expectation that the information would not be disclosed.

Where a patient has died access shall not be given to any part of the record, which in the opinion of the record holder, would disclose information which is not relevant to any legal claim which may arise out of the patient's death.

The whole, or part exemptions are the only circumstances in which access may be limited or excluded.

Please circle the appropriate instruction number.

INSTRUCTIONS TO THE ACCESS TEAM OFFICE

1. Photocopy the requested records..
2. Reason for withholding information:
(If you decide to withhold any of the requested information, the requestee must be informed in writing as to the reason why.)

.....

.....

.....

Consultant's Signature Date:

Please return to:- Access Team Office
 Health Records Department
 Level 7
 Ninewells Hospital

Please ensure that the case records are tracked out on iFIT to the following location:

Doc.M

Access Team
Health Records Department
Hospital Address
Telephone Number: *(insert)*
Fax Number *(insert)*
www.nhstayside.scot.nhs.uk

Date
Your Ref
No:
Our Ref

Enquiries
to
Extension
Direct Line
Email

Dear Sir/Madam

Thank you for your request for medical records of the above. Permission has been requested for release of records.

We will endeavour to forward the requested records as quickly as possible and before the statutory time limit of 31 days. If we cannot, we will inform you of any delay.

Yours faithfully

Authorised Signature

Acknowledgement Receipt

Request letter to other services

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY
 Telephone Number: (01382) 660111
 www.nhstayside.scot.nhs.uk

Your Ref
 Our Ref
 Enquiries to
 Extension
 Direct Line
 Email

Access Team

CAT E

CAT E

CAT E

Monday, 24 June 2024

Dear Sir/Madam,

Name	DOB/CHI	Incident Date/s	Signed off:

The above patient has signed a mandate for a copy of any medical records you hold. Please ensure that these are copied accordingly.

We require your response within **5 working days** in order that we can comply with governed time-scales.

Please note if the clinician is on Leave of Absence or Holiday. The request may be passed to the Lead Clinician/Administration Manager or the appropriate secretary, to ensure the task is not unduly delayed.

Please sign and release.

If you have any objection to the release, this must be explained in writing and returned to this office.

Yours sincerely,

Access Team

Doc.N

STANDARD OPERATING PROCEDURE

TRANSFER OF COPY/ORIGINAL RECORDS TO OTHER HOSPITALS

The request should be received in writing.

.

1. If the patient has an appointment within 21 days, do not send the originals, please use common sense with this approach.
2. Track the case records movement in iFIT, including contact details of the requester.
3. Copy and send the case records by Recorded Delivery to the requesting hospital.

STANDARD OPERATING PROCEDURE

PATIENT INSURANCE FORMS

Patient Insurance Forms

Log request on spreadsheet on SAR shared drive.

These forms may arrive via mail or be brought in by the patient.

Check if the Company is on the free or pay list (see office list).

Check Patient ID of policy holder. Check details on TrakCare and enter on form, sign and stamp with the hospital stamp – no charge to patient.

.

STANDARD OPERATING PROCEDURE

REQUESTS FOR MEDICAL REPORTS FROM:-

**SOLICITORS
INSURANCE COMPANIES
AGENCIES, e.g., DVLA**

Requests for Medical Reports from Solicitors/Insurance Companies/Agencies

1. Log request on spreadsheet on SAR shared drive.
2. When these requests arrive they should be dealt with as soon as possible. Request letters are received via the consultant's secretary or direct from solicitors/insurance companies.

If requests come direct to the Access Office from the solicitor/insurance company, they must be accompanied by a signed mandate from the patient, or patient's representative for a child or deceased person.

Check every 14 days until report is completed. After 28 days escalate non-completion to Locality Health Records Manager.
3. Take the following actions:-
 - 3.1 Locate any records (Medical Records/A&E Sheets) held regarding the patient for the date requested.
 - 3.2 Send the records along with a note regarding x-rays and a cover letter and original request to the consultant's secretary (Doc.H).
 - 3.3 File a copy of the solicitor/insurance company request in the appropriate folder.
 - 3.4 When the receipt arrives from the Cashier's Office send to the solicitor/insurance company with a compliments slip.
 - 3.5 File the original request appropriately.

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY
 Telephone Number: (01382) 660111
 Fax Number: (01382) 632349
 www.nhstayside.scot.nhs.uk

(Recipient's Name)
 Address 1
 Address 2
 Address 3
 Address 4

Date
 Your Ref
 Our Ref
 Enquiries
 to
 Extension
 Direct Line
 Email

Dear Sir/Madam

Name, Address & CHI of Patient

Please find enclosed a letter from (solicitors/insurance company name or DVLA) requesting a medical report on the above named patient.

It should be made clear that you will be acting in an independent and personal capacity in providing the report. This office only provides an administration service between the solicitors, the doctor and the patient concerned.

You should render a note of your fee along with the report when it is available.

Yours faithfully

Access Office

Please return this form to the Access Office for our records

Instructions to the Access Office

Please circle the appropriate instruction number:

1. I will undertake the task as requested and forward the report in the attached business envelope.
2. The request has been passed to(Consultant/Doctor).
3. I am unable to prepare a report.

N.B. Please return this form to the Access Office. We are required to inform the Agent (within 15 days) that we shall/shall not process the request.

There is no legal requirement for provision of a factual report, unless directed by the Court Services.

(Doc.H)

STANDARD OPERATING PROCEDURE

SUBJECT ACCESS REQUEST FROM:-

**PATIENT
GUARDIAN/REPRESENTATIVE/RELATIVE**

PROCEDURE FOR PROCESSING APPLICATIONS FOR ACCESS TO HEALTH CARE RECORDS

The following procedure should be followed when written or oral requests for access to health records are received.

1. Advise the patient or their representative that there is a requirement to complete an Application for Access to Health Records form, THB(MR)458 (example attached to procedure).
2. On receipt of the request, the Access Team will:-
 - Log request on spreadsheet on SAR shared drive.
 - Source the "Access to Your Health Records" form (THB(MR)459) and attach the letter of explanation re preferred choice (Doc.D & Doc.E).
 - Send the above to the patient/representative.
3. On receipt of the completed Access to Health Records Application form the Access Team will:-
 - Check that the application form has been completed correctly by the applicant/representative of the applicant and date stamp.
 - Obtain the health record and refer to the appropriate health care professional (using Doc.F) for advice. If the information is "old information" and the health care professional is no longer employed by NHS Tayside, the application should be referred to the appropriate Clinical Lead or Director of Medical Services.
4. The health care professional will, on receipt of the application for access to health records:-
 - Advise the Access Team on the access to be allowed, ensuring that he/she has sought the view of other health professionals who have had a significant input into the patient's care.
 - The health care professional should:-
 - Decide whether to allow the patient to inspect the record.
 - If the patient can only see an extract, prepare the extract to be given to the patient.
 - Advise the Access Team whether (i) or (ii) and whether or not he/she considers he/she should be present when the patient is to inspect or receive the health record in order to provide explanations or counselling to the patient or patient's representative, or
 - Advise the Access Team where this can be supervised by a lay person (normally the local Records Manager or deputy(ies)).
 - Complete the permission slip (Doc.F) and return casenotes and permission slip to Access Team.
 - 5 day chase-up if not completed by Clinician.
5. The Access Team will be responsible for ensuring that any photocopies required by the applicant are provided.
6. This request should be completed within the 31 days allowed by the General Data Protection Regulation
7. Contact Patient by telephone or by using Doc.G – standard letter to send to patient/guardian/representative/relative to invite them to come to Medical Records to view the health record with a Medical Records Manager in attendance.

Access Team
Health Records Department
Level 7
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: (01382) 660111
Fax Number: (01382) 632349
www.nhstayside.scot.nhs.uk

(Recipient's Name)

Address 1

Address 2

Address 3

Address 4

Date

Your Ref

Our Ref

Enquiries

to

Extension

Direct Line

Email

Dear

ACCESS TO HEALTH RECORDS (DPA2018)

Thank you for your request to access your health records. Please complete the enclosed "Access to your Health Records" form and enter your preference in the box provided in the attached letter.

Please forward the completed form and the preferred choice letter in the envelope provided.

NB: It is essential that the "Countersignature" section of the application form is completed by a professional person to confirm your identity.

Yours sincerely

Authorised Signataure

Doc.D

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY
 Telephone Number: (01382) 660111
 Fax Number: (01382) 632349
 www.nhstayside.scot.nhs.uk

(Recipient's Name)
 Address 1
 Address 2
 Address 3
 Address 4

Date
 Your Ref
 Our Ref

 Enquiries
 to
 Extension
 Direct Line
 Email

Preferred Choice

Please tick your preferred choice:-

- (A) ☐ You may request an appointment with the appropriate Consultant/Doctor. This is desirable as any unintelligible part(s) of the records can be explained to you.
- (B) ☐ You will look through the records in the presence of a Manager from the Health Records Team and decide which records you require to be copied. **(Please be advised that the Manager is unable to comment on the contents of your records.)**
- (C) ☐ Request that the relevant records be photocopied and sent direct to you by Recorded Delivery.

The copy records will be sent by Recorded Delivery to your home address.

Please enclose both the Access Form and the Preferred Choice letter in the addressed envelope supplied.

General Data Protection Regulation – The task must be completed in 31 days from receipt of the completed forms and/or from the identification of the information contained in the attached.

REQUEST FOR MEDICAL RECORDS**PERMISSION SLIP**

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY
 Telephone Number: (01382) 660111
 Fax Number: (01382) 632349
 www.nhstayside.scot.nhs.uk

To:

Re:

I have received an Access to Health Records form from:

requesting access to

I would appreciate your instructions on the action to be taken. Can you please circle the appropriate instruction number?

Health Records Manager

Date:

INSTRUCTIONS TO HEALTH RECORDS MANAGER

1. A photocopy of the requested record should be sent to the enquirer along with any data held electronically. (Any requested information withheld will be subject to explanation by the clinician.)
2. I shall write to the person making the request to arrange a suitable appointment.
3. I give permission for the requestee to view the record in the presence of an appropriate Records Manager/Managers.
4. Other (please specify)

Consultant's Signature

Date:

Date Sent:

Please note that there may be cases where partial access may be extended including:

Where in the opinion of the holder of the record the information may cause serious harm to the physical or mental health of the patient, or other individual.

Where information provided by a third party, who would be identified from their information. You do not have to have to disclose information about another individual who can be identified from the information, except if:

- ***The other individual has consented to the disclosure; or***
- ***It is reasonable to comply with the request without that individual's consent***

And in determining whether it is reasonable to disclose the information, you must take into account all the relevant circumstances, including:

- ***The type of information that you would disclose;***
- ***Any duty of confidentiality you owe to the other individual;***
- ***Any steps you have taken to see consent from the other individual;***
- ***Whether the other individual is capable of giving consent; and***
- ***Any express refusal of consent by the other individual.***

Where an application is on behalf of a child or pupil, or where the patient is incapable of managing his/her own affairs, or where a patient has died, access may be refused to that part of information provided by the patient, in the expectation that it should not be disclosed to the applicant, or where information was obtained as a result of examinations to which the patient consented in the expectation that the information would not be disclosed.

Where a patient has died access shall not be given to any part of the record, which in the opinion of the record holder, would disclose information which is not relevant to any legal claim which may arise out of the patient's death.

The whole, or part exemptions are the only circumstances in which access may be limited or excluded.

Doc.F

Access Team
 Health Records Department
 Level 7
 Ninewells Hospital
 DUNDEE
 DD1 9SY

Telephone Number: (01382) 660111 Ext. **CAT E**

Fax Number: (01382) 632349

www.nhstayside.scot.nhs.uk

(Recipient's Name)

Address 1

Address 2

Address 3

Address 4

Date

Your Ref

Our Ref

Enquiries

to

Extension

Direct Line

Email

Dear

We can offer you the following dates to view your medical records with a Health Records Manager in attendance:-

Date:

Date:

Date:

Please telephone to confirm which of the above dates is most convenient for you. If you are unable to attend any of the above, please call the above telephone number to arrange an appointment that suits you.

If you have any queries, please contact the office detailed below:-

Access Office
 Medical Records Department
 (Hospital address)

Tel: (telephone number)

Yours sincerely

Authorised Signature

c.c. (Name), Assistant Medical Records Manager, (Name of Hospital)

Doc.G

STANDARD OPERATING PROCEDURE

RELEASE OF MEDICAL RECORDS: PROCURATOR FISCAL

PROCEDURE FOR PROCESSING APPLICATIONS FOR RELEASE OF HEALTH CARE RECORDS TO PROCURATOR FISCAL

When requests for medical records arrive from the Procurator Fiscal's office they should be dealt with as soon as possible, **within seven days**.

The requests may come via the police but they will need written authorisation from the Procurator Fiscal in order for the records to be released. This authorisation may come via fax and e-mail. The police may wish to come and collect the records themselves.

Take the following actions:-

1. Log request on spreadsheet on SAR shared drive.
2. Locate any records/electronic records/casualty sheets we have for the person named in the request.
3. Any records located must be photocopied, depending on whether the request is for originals or copies, and should be sent to the Fiscal's office. Original records are always supplied for Post Mortems.
4. If the records are being sent by post, produce Doc.P.
5. "Certification of Document" – this certificate will be signed and returned to the Procurator Fiscal's office with the officer collecting the case notes.
6. Sign Doc.P if one was produced.
7. By Post: Send the copies of the medical records and original x-rays to the Fiscal's Office via Recorded Delivery. Include the following documents:-
 Doc.P on letter-headed stationery
 Doc.Q (if applicable).
8. By Hand: e.g., when picked up by the police: give them the copies of the medical records and original x-rays for the Fiscal's Office and Doc.Q. Police must sign release form (copy held with policy signatory by department other one with records).
9. We keep:
 The Fiscal's request.

When the original records are returned from the Fiscal, the copy records in the patient's records should be replaced with the originals and the copies kept in the Access Office.

Access Team
Health Records Department
Hospital Address
Telephone Number: (*insert*)
Fax Number (*insert*)
www.nhstayside.scot.nhs.uk

Fiscal's address

Date
Your Ref
No:
Our Ref

Enquiries
to
Extension
Direct Line
Email

Dear Sir or Madam

CASE AGAINST:

I refer to your letter dated and now enclose medical records for this patient:-

Name:

Date of Birth:

Date of Admission/Incident:

I look forward to the return of these records when your purpose with them is through.

Yours faithfully

Authorised Signature
Access Office
Health Records Department
(*Hospital*)

Doc.P

Release Form

Access Team
 Health Records Department
Hospital Address
 Telephone Number: *(insert)*
 Fax Number *(insert)*
 www.nhstayside.scot.nhs.uk

Fiscal's address

Date
 Your Ref
 No:
 Our Ref

Enquiries
 to
 Extension
 Direct Line
 Email

Principal Medical Records Certificate

I, *(name)*, *(job title)*, *(Hospital and location)*, hereby certify that the documents listed and described below and to which this certificate is attached, are documents kept by an undertaking, namely Tayside NHS, *(Hospital and Location)*.

Medical Records certified as business documents in terms of Schedule 8 of the Criminal Procedures (Scotland) Act 1995.

Signed

Medico-Legal Officer, authorised to give
 Evidence on behalf of the said Tayside NHS.

Date.....

List and description of documents

Medical file relative to:

--	--	--

Containing

Original Records:-

Delete as necessary: Release to Tayside Police/Procurator Fiscal's Office/University Post Mortem.

Position/Name (Print)

..... Signature

This is an example of Procurator Fiscal's paperwork.

I (name) (job title)

hereby certify that the documents listed and described below are documents held by (Hospital name) on behalf of NHS Tayside.

Signed

Date/...../.....

..... (print job title)

Medical records relating to (patient name) born (date of birth) pages 1 to (...) inclusive.

Doc.Q

This is an example of Procurator Fiscal's paperwork.

CERTIFICATE OF AUTHENTICATION

I (name) (job title)

(Hospital name) being the person in possession and control of the original of the copy document on which this certificate is endorsed (or to which this certificate is attached) hereby certify that it is a true copy of a material part of the original which is in my possession and control.

Date Signed

Medical records relating to (patient name) born (date of birth) pages 1 to (...) inclusive.

Example of Inventory

STANDARD OPERATING PROCEDURE

RELEASE OF MEDICAL RECORDS: COURT ORDERS

PROCEDURE FOR PROCESSING APPLICATIONS FOR RELEASE OF HEALTH CARE RECORDS IN RESPECT OF COURT ORDERS

The undernoted procedure should be followed when Court Orders are received:-

Court Orders – when copy of Court Order supplied

When Court Orders arrive, they should be returned **within seven days**.

1. Log request on spreadsheet on SAR shared drive.
2. Use "Specification of documents" to locate any records we have regarding the "Pursuer" for the date requested.
3. Any records (paper or electronic) must be photocopied/printed (we keep the originals) – only copy what has been requested.
4. Check if there are any x-rays and send a copy of the completed request to Radiology
5. Produce Doc.R and Doc.S. Print two copies of Doc.R – one on plain paper and one on letter-headed stationery.
6. Cross out the sections of the "Certificate" that don't apply.
7. Sign the "Certificate", Doc.S and Doc.R.
8. Photocopy the "Court Order", the "Certificate", the "Specification" and two copies of Doc.S.
9. Send the copies of the health records and Doc.T (double-wrapped) to the address on the "Court Order" via Recorded Delivery. Include:- the following documents:-
 - "Court Order" (the original)
 - "Certificate" (the original)
 - "Specification" (the original)
 - Doc.R on letter-headed stationery
 - Two copies of Doc.S.
10. We keep:-
 - Doc.R (the one on plain paper)
 - "Court Order" (the copy)
 - "Certificate" (the copy)
 - "Specification" (the copy)
 - A copy of Doc.S
 - "Interlocutor" (the original)
 - Plus any documents we received that weren't returned in the previous action (9.).

Court Orders – with Specification only (for personal injury actions)

When Court Orders arrive they should be returned within seven days.

1. Log request on spreadsheet on SAR shared drive.
2. Use "Specification of Documents" to locate any records we have regarding the "Pursuer" for the date requested.
3. Any records (paper/electronic) located must be photocopied/printed (we keep the originals) – only copy what has been requested.
4. Check if there are any x-rays and send a copy of the complete request to Radiology who will arrange to have the x-rays copies and sent back to the Access Office.
5. Produce "Cover Letter" and Doc.S of documents for the Court. Print two copies of "Cover Letter" one on plain paper and one on letter-headed stationery.
6. Produce two copies of "Cover Letter/Invoice" for the requesting solicitor – one on plain paper and one on letter-headed stationery.
7. Cross out the sections of the "Certificate" that don't apply.
8. Sign the "Certificate", Doc.S, "Cover Letter" and the "Cover Letter/Invoice".
9. Photocopy the "Court Order", the "Certificate", the "Specification" and two copies of Doc.S.
10. Send the copies of the health records (double-wrapped) to the address on the "Court Order" via Recorded Delivery. Include the following documents:-
 - Doc.T
 - "Court Order" (the original)
 - "Certificate" (the original)
 - "Specification" (the original)
 - "Cover Letter" to the Court on letter-headed stationery
 - Two copies of Doc.S.
11. Send the copy of "Cover Letter/Invoice" to the requesting solicitor via Recorded Delivery.
12. We keep:-
 - "Cover Letter" and "Cover Letter/Invoice" (the ones on plain paper)
 - "Court Order" (the copy)
 - "Certificate" (the copy)
 - "Specification" (the copy)
 - A copy of Doc.S
 - The "Interlocutor" (the original)
 - Plus any documents we received that weren't returned in action (10.).

Access Team
 Health Records Department
Hospital Address
 Telephone Number: (*insert*)
 Fax Number (*insert*)
 www.nhstayside.scot.nhs.uk

Solicitor's address

Date
 Court Ref
 No:
 Our Ref
 Enquiries
 Extension
 Direct Line
 Email

Dear Sir or Madam

Specification of Documents:

Pursuer's name v Defender's name

By Terms of the Order by the Sheriff Court, I herewith enclose:-

1. The Specification itself.
2. Copies of all relevant documents and x-rays.
3. Two signed inventories.
4. A signed Certificate.

Yours faithfully

Access Team Office
 Health Records Department
 Level 7
 Ninewells Hospital
 DUDEE
 DD1 9SY

N.B. *NHS Tayside Financial Services will invoice you for the provision of Court Order specification documents. There is a charge of £50 to cover photocopying and administration of this request.*

Doc.R

**INVENTORY
OF
COPY CASE RECORDS**

1. All medical records and nursing notes from **(Hospital name)**.
2. Copy x-ray disc **(insert date)**.

Date:

Court Ref:

Your Ref:

Our Ref:

Yours faithfully,

(Name)
Access Team
Health Records Department
Hospital Address

Ref:

Doc.S

Access Team
Health Records Department
Hospital Address
Telephone Number: *(insert)*
Fax Number *(insert)*
www.nhstayside.scot.nhs.uk

RECORDED DELIVERY:

Date
Court Ref
No:
Our Ref

Enquiries
to
Extension
Direct Line
Email

Dear Sir/Madam

By Terms of the Order of the Sheriff Court of , I herewith enclose:-

1. The Specification itself
2. Copies of all relevant documents and x-rays
3. Signed inventory
4. A signed Certificate.

Yours faithfully

Authorised Signature
Access Team Office
Health Records Department
(Hospital)

N.B. *NHS Tayside Financial Services will invoice you for the provision of Court Order specification documents. There is a charge of £50 to cover photocopying and administration of this request.*

Doc.T

Request for Electronic Transfer of Imaging (IEP)Email request to **CAT E****Requestor Details** * please complete all fields

Name	Access Team
Position	Clerical Officer
Department	Health Records, Level 7, Ninewells
Email	CAT E
Telephone	CAT E
Date of request	Monday, 24 June 2024

Reason for Request

ACCESS

Patient Information * please complete all fields

CHI number	
Forename	
Surname	
Mobile Telephone Number	
E-mail address (1)	
E-mail address (2) For overseas requests only	

Examinations requiring replication * please complete all fields

Date of examination *must be completed	Examination Type *please give as much information as possible
	X-RAYS, MRI, CT SCAN

Doc.X

NHS Tayside Health Records Service Operating Procedure

Number 14: Filing of Loose Documentation

1. Opening Statement

During the course of a patient's treatment within the hospital many documents and reports are produced by the various clinical and laboratory departments concerned with the patient's care. These documents and reports arrive at a variety of destinations within the hospital. Health Records, ward clerks and medical secretarial staff are responsible for ensuring loose documentation is timeously and correctly filed within the Health Record folder.

Non-Clinical Correspondence: Only clinical correspondence should be filed in the patient's health records. Documentation relating to complaints or enquiries from patients should be held separately in a complaints/management file.

From 1st June, 2020 documents that are stored on TrakCare and the Clinical Portal should not be printed and filed in the paper case records. This includes documents such as referral letters, correspondence and laboratory results.

The benefits of viewing results and letters via electronic systems is that this is the source of the most up-to-date information, available 24/7 and to more than one clinician at a time from multiple locations.

Correspondence stored on electronic systems such as Dermabase will continue to be printed and filed in the paper case records until this information is accessible via the Clinical Portal.

2. Health Records Department

The Health Records Department is not responsible for the filing of loose documentation in the Health Record. As far as possible all letters, laboratory reports, etc., should be filed at source. Staffs within the library area are responsible for the return of all loose filing to the location where it was produced. Where the documentation is to be filed in case notes outwith the site, e.g., a Perth patient is seen at Plastic Surgery Ninewells but without the Perth case notes – any documentation produced from the consultation should be forwarded to the Records Library at Perth Royal Infirmary for inclusion in the notes. Health records filed within the libraries at Ninewells and Stracathro, should be requested to file loose filing in. The Mental Health Records Dept forward on to the locality where the record is being held any loose documentation for filing.

On occasion there may be local arrangements in place for filing to be sent to the Health Records Department for filing e.g. when case records are not required at clinic but documentation produced.

3. Medical Secretarial Level

Secretaries should file all loose documentation within the Health Record before returning it to the filing library. If filing is generated after the records have been returned to file then the secretary needs to request the Health Record from the relevant filing library and file the loose documentation correctly in the Health Record on receipt. Alternatively, the secretary can go to the relevant filing library where the health records are housed. The accountability lies with the secretaries to carry out this procedure.

4. Ward Level

Ward clerks should file all loose documentation within the Health Record before the record leaves the ward. In the event of Health Records not being available the ward clerk should pass on the paperwork to the appropriate secretary who should follow the procedure detailed in 3. above.

5. Accident and Emergency

Loose filing/documentation within the Accident and Emergency Department should be filed with the Health Record by the Accident and Emergency Secretary if there is one attached to the Department.

If Health Records are not available on admission then the Accident and Emergency Secretary is accountable for tracing the record and filing into it accordingly. If the patient is admitted then the loose filing would go with the patient to the appropriate ward and would be filed in the Health Record by the ward clerk following procedure **4.** above.

Reference

Records Management: Health and Social Care Code of Practice (Scotland) 2020

Links

PRIMAP Standard 3 (point 3.15)

NHS Tayside Health Records Service Operating Procedure

Number 15: Provision of SMRs

1. Opening Statement

Clinical and health related data are collected on various national patient based datasets by Public Health Scotland (PHS) to support a variety of purposes including epidemiology, service planning and performance management. The information is also used to support policy making decisions aimed at improving the health and healthcare of the people of Scotland. To ensure that data is recorded consistently and accurately, to facilitate analyses and to provide meaningful comparisons, nationally agreed clinical coding systems are used.

The Scottish Government target for SMR submission to PHS is 6 weeks (42 days) following discharge/transfer/death or clinic attendance. PHS calculates timeliness as data received 6 weeks following the end of month of discharge/transfer/death or clinic attendance e.g. all SMR01 records with a March 2011 date of discharge/transfer/death would be expected to be submitted to ISD by 12th May 2011.

N.H.S. Tayside expects that SMR's for submission are completed by the Wednesday prior to the submission by date.

2. General Principle

An **SMR00** is generated for Patients receiving treatment as **Outpatients**

An **SMR01** is generated for patients receiving care as **Inpatients and Day cases**.

An **SMR02** is generated for patients receiving care in the **Obstetrics Specialties**.

An **SMR04** is generated for patients receiving care in **Mental Health** as **Inpatients and Day Cases**

For further information on the generation of S.M.R's, see I.S.D. Data Dictionary at:

<http://www.isdscotland.org/index.asp>.

3. Process & Responsibilities

All SMRs are automatically generated by TrakCare.

- **SMR00s** are generated for all new referrals and for those patients receiving a procedure at the clinic.
 - Clinicians will be responsible for the completion of the 18 week RTT and clinic outcomes on TrakCare
 - The Clinician seeing the patient will be responsible for the procedure coding, using the barcodes provided.
- **SMR01s** are generated for all Inpatients and day cases on discharge/transfer/death.
 - The Clinical Team looking after the patient should complete a discharge letter/summary no later than 2 weeks after the discharge/transfer/death of the patient.
 - The Coding staff will be responsible for the completion and final validation of the record; this includes all admin/demographic details as well as the diagnostic and procedural coding. The coding should be completed using ICD 10 and OPCS 4 to the agreed national standards. This should be completed by the Wednesday prior to the submit by date.
- **SMR02s** are generated for all Inpatients and Day cases who are receiving Maternity care
 - The Obstetric team/Midwife will be responsible for recording maternity data on Badgernet.
 - Coding staff responsibilities will be the same as that, for the **SRM01**
- **SMR04s** are generated for all Inpatients and Day cases admitted to the Mental Health specialties.
 - Part 1 of the SMR04 should be completed on admission, including admission diagnosis.

- The remainder of the SMR should be completed as per the SMR01 and the responsibilities leading up to completion should be the same.

The TrakCare Team will be responsible for the extraction of the data on the Wednesday of each week. It may be necessary at times to do an additional extract on the SMR submission date, thus ensuring that the maximum completed data is received by ISD within the timescales allowed. Completeness and Backlog Reports to be produced by Health Records/Coding Manager and sent to PHS on the submission date.

Reference

Data Protection Act 1998

Access to Health Records Act 1990

Computer Misuse Act 1990

Records Management: NHS Code of Practice (Scotland) 2012

ISD Data Dictionary. : <http://www.isdscotland.org/index.asp>

I.C.D. 10

O.P.C.S. 4.7

NHS Tayside Health Records Service Operating Procedure

Number 16: Requesting Case Records for Audit

1. Opening Statement

To ensure that case record audits can be carried out in a safe and timely manner without disruption to availability of case records required for patient care.

2. Procedure

When health records are required for audit purposes please contact the Health Records Department and discuss audit requirement. An Audit Request Form will be emailed out to the requester which should be completed and returned to the Health Records Manager at the relevant Health Records Department (Ninewells/PRI/Strathro/Dundee Dental Hospital/Carseview/Murray Royal Hospital).

A fee of £8.60 per hour is charged for audit work carried out by Health Records but there may be occasions when this fee is waived due to small numbers requested. This will be cross-charged via the Finance Department to the relevant department. The financial code must be completed on the Audit Request Form before any work will be undertaken.

All audit lists must include patient's forename, surname and date of birth/CHI. Please note that if incorrect information is provided then the Health Records Department will be unable to locate case records.

Health Records will locate case records for audit in batches of 15-20 case records at pre-arranged intervals. It is recommended that case records are viewed within the Health Records Department instead of taking case records to a department as this will save time for staff looking for case records throughout the hospital in the event of a patient record being required for an admission or OP appointment.

A case record location has been set up called "Audit" which will be used for all audit lists with the name of the requester added to the comment box.

Please note – agreed interval for pulling audits is dependent on workload in the Health Records Department as audits will not be treated as a priority.

If junior doctors wish to locate their own case records for audit, thus not incurring any charge, please contact the Health Records Department and discuss audit requirement.

Training will be provided by the Filing Room Admin Assistant on locating and tracking case records.

NHS Tayside – Health Records Department Audit Request Form

Date of Request:

Purpose of Audit:

Financial Code:

Name:

Department:

Ext No:

e.mail:

Please ensure that all section of the form are completed before submission to Health Records Manager

[illegible]

NHS Tayside Health Records Service Operating Procedure

Number 17: Recording of Advanced Directives

1. Opening Statement

To ensure that paper case records and Patient Administration System are marked appropriately to indicate that an Advanced Directive is in place.

Examples of Advanced Directives:

- Power of Attorney Documents
- Guardianship Documents
- Do Not Resuscitate Forms (DNR)
- Declaration of Bequest (body to medical science)
- Nomination of Named Person (under Mental Health Act)
- Advanced Statement (Mental Health)

2. Procedure

All Advanced Directives such as Living Wills should be forwarded to the Health Records Manager in your area. Advanced Directives can also come into the Health Records Manager from patients and solicitors.

Health Records Managers will:

- Check patients details on Patient Management System (TrakCare) and record "Advanced Directive" in the Alert tab in the patient demographic screen.
- Living Wills should be recorded in the Living Wills Category and Power of Attorney should be recorded in the Administrative Category. There is an additional information box where other information can be added e.g. Guardianship Order.
- Scan the documents into TrakCare in the same way as referrals are scanned into the EPR. Update the description as Living Will, Power of Attorney, etc.
- Take a copy of the Advanced Directive for each locality case records and forward this to the relevant Health Records Manager requesting that they put a copy in their case records and mark case records accordingly.
- Place a yellow Advanced Directive sticker on the front cover of the case records and file a Advanced Directive in front of the Abstract Sheet.
- Write to the patient/solicitor advising that the Advanced Directive has been dealt with.
- Record details on spreadsheet/database.

PRIVATE AND CONFIDENTIAL

Name

Address 1

Address 2

Address 3

Postcode

Date 28TH July 2015

Your Ref

Our Ref

Enquiries to Evelyn Petterson

Extension CA E

Direct Line CAT E

Email CAT E

Dear

Advanced Directive (Living Will)

Thank you for sending me the above document. The Patient Administration System has been updated and a copy of the living will has been prominently filed in your case records at Perth Royal Infirmary. I have forwarded a copy to Health Records Manager, Ninewells Hospital, Dundee to file in your Ninewells case records.

I would be grateful if you could inform me if the above document is retracted or amended in order that your case records can be updated.

Yours sincerely

Health Records Manager

Perth & Kinross/Angus

c.c. Health Records Manager, Dundee Locality, Ninewells Hospital, Dundee

NHS Tayside Health Records Service Operating Procedure

Number 18: Procedure for the development of new / updated clinical documentation.

1. Opening Statement

There is a requirement to follow a standardised procedure for the development of new or updated clinical documentation. This is to ensure that there the correct versions or documents are in circulation, each document is suitable for scanning in the future and that each document has a unique THB number. New and updated documentation has to go through the Nursing Documentation Steering Group for approval/

2. Procedure

There are 3 parts to the process for the development of new / updated clinical documentation:

- Development
- Approval
- Implementation

Details of the procedure are attached below

PROCEDURE FOR THE DEVELOPMENT OF NEW / UPDATED CLINICAL DOCUMENTATION

Stage 1 Development

Identify if an update of a **current** clinical document is required, or identify the need for a **new** clinical document.

Submit proposals and/or amendments to **CATE** for approval by Electronic Patient Record Steering Group. (EPR) Once approval has been granted from EPR, proceed to next step.

Clinical Document Owner to seek approval from local Clinical Care and Professional Governance Group (CCPGG) /Clinical Care Group (CCG) Triumvirate to develop new clinical document/amend current clinical document.

- Develop draft clinical document (Microsoft Office only)
- Amend current clinical document.
- Use improvement methodology/tests of change to ensure that the document fulfils the desired purpose.
- Update as required, ensuring [Document Version Control](#).
- Consider any positive and/or negative impact the clinical document could have on any population groups.
- Undertake [Equality Impact Assessment](#)

Consider:

- Are there legal requirements/implications? e.g. Consent.
- Are there professional/clinical standards that need to be reflected?

Consultation

- Circulate the draft clinical document, after initial tests of change, to appropriate staff groups for consultation, including Clinical Governance structures.
- Collate comments and amend document as appropriate, maintaining version control, to produce the "final" version.
- Consider if existing stock levels need to be used/disposed of.

Consider:

- Obtaining patient feedback.
- Notifying procurement if this will require changes to their document orders and current stock if a previous version is being superseded.
- The timescale to use up existing stocks in clinical areas and stores.
- The risk to the Service of not implementing the new document immediately and the potential cost/impact of withdrawing old versions from use.

Stage 2 Approval

Complete **Clinical Documentation Specification Proforma Section 1**; and submit with draft new/amended clinical document to the relevant CCPGG/CCG Triumvirate for approval.

- Make further amendment if advised by the GPGG/CCG.
- Achieve sign off through CCPGG/CCG Triumvirate.
- Complete the Clinical Documentation Specification Proforma **Section 2** clearly detailing: approval date; quantity of stock required annually; and number of copies to be kept in clinical areas.
- Identify cost/impact of withdrawing old versions from use; identify financial code.

Once approved by the CCPGG/CCG Triumvirate **submit to the Clinical Policy Governance Group**.

Stage 3 Implementation

Submit the Clinical Documentation Specification Proforma and approved clinical document (in Word format) to the Clinical Policy Governance Group for approval of allocation of THB number.

E-mail: **CATE**
Meetings are held bi-monthly.

Clinical Policy Governance Group will review the development/amendment process and, once assured, will approve the allocation of a THB number.
Clinical Policy Governance Group to complete Clinical Documentation Specification Proforma **Section 3**.

- The Clinical Policy Governance Group will advise Clinical Document Owner that the new/amended clinical document has been approved for the allocation of THB number. Providing completed Clinical Documentation Specification Proforma and approved clinical document.
- Clinical Document Owner will submit Clinical Documentation Specification Proforma and approved clinical document (Word format) to **CATE** who will allocate a THB number.

- E-mail confirmation of the THB number will be sent to the author and document owner (Service that initiated the new document or approved the revision of the document). NB An approved existing clinical document will keep the same THB number as before.
- A review date of 1 year will be set for new documents and 3 years for existing amended/updated documents.
- Authors will be invited to update the CCPGG of the effectiveness of the clinical

Stage 4 Supply

New or Reviewed Documentation:

Please share the Specification Proforma with confirmation of 'approval' and 'approval of allocation of THB number' complete.

Procurement of approved new/revised clinical documentation should submitted to
CAT E

Document owner to roll out the communication and implementation plan to document users.

Approved New/Revised document

MORE than 250 copies per year and multiple users will be kept as stock, to be ordered via [PECOS](#).

New document

- Contact **Logistics Team** **CAT E** to allocate a Stock Location Number and advise of stock numbers to be kept.
- Send new document and Specification Proforma electronically to the **Operational Procurement Team**:
CAT E
 to raise stock purchase order/liaise with Tayside Print Unit or external print company.

Revised document

- Document owner to contact Operational Procurement Team.
- Proofs to be approved by document owner.

Approved New/Revised Document:

LESS than 250 copies, single user then this will be non stock, printed locally and ordered through Non Stock requisition.

New document

- Send new document electronically and Proforma to **Tayside Print Unit**. Discuss projected yearly usage and specification. Copy in the Operational Procurement Team
- If print room unable to process the request contact Operational Procurement Team.

Revised document

- Document owner to contact Tayside Print Unit directly.
- Proofs to be approved by document owner.

Document owner to develop and communicate an implementation plan to document users.

Stock items

Document owner will be responsible for using up old stock or for instruction to remove old stock.

NB withdrawal of old stock may incur a cost and a financial code for disposal will be required. Procurement will advise.

Non stock

Document owner responsible for communication to clinical areas to remove/use up/dispose of old stock as necessary.

CLINICAL DOCUMENTATION SPECIFICATION PROFORMA

Title of document:	
Brief description of purpose of the document:	
Rationale for development:	
Planned timescale of development:	
Name and contact details of main author Name: Job title: Service: Main base: Phone: E-mail address:	
Name of working group developing the document (or names and title of people involved):	
Which people / groups / departments have been involved in the consultation about the document?	
How has the consultation been carried out? (brief details)	
Attach completed Equality Impact Assessment	
Document Specification Check (see example, Appendix 1)	
Arial font (preferably 11 or 12 pt)	Yes ☐ No ☐
Patient demographics included	Yes ☐ No ☐
Text box for barcode	Yes ☐ No ☐

Footer contains:		
Document owner (Name & Service)	Yes ☐	No ☐
Date developed	Yes ☐	No ☐
THB Number and version Included in footer	Yes ☐	No ☐
New document requires THB number	Yes ☐	No ☐
		Allocated THB:

Local Clinical Care and Professional Governance Group approval:	Date:
Chair of local Clinical Care and Professional Governance Group Chair and Service Lead / Clinical Care Group Triumvirate	
Name:	Name:
Title:	Title:
Date:	Date:

Clinical Policy Governance Group approval:	Date:
Chair agreement of adoption by NHS Tayside	
Name:	Name:
Title:	Title:
Date:	Date:

PRINTING REQUEST

Where will this document be applicable for use: Service(s): Minimum quantity required annually to be printed: Number of copies to be kept in clinical area:
--

Copy Information	Copy Size	Finishing Requirements
Colour ☐	Origination	Stapled Sets
Black & White ☐	A5 ☐	1 staple ☐
Single sided ☐	A4 ☐	2 staples ☐
Double sided ☐	A3 ☐	Booklet format ☐
Portrait ☐	Other ☐	Wire-o Bind ☐
Landscape ☐	Finished Size	Laminate ☐
Paper ☐	A5 ☐	Guillotine ☐
Card ☐	A4 ☐	Hole Punching
	A3 ☐	2 Hole Punched ☐
	Other ☐	4 Hole Punched ☐
If coloured paper or card is required please specify colour 		

Stock Location Number (Bin Number)	
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**NO PRINTING WILL BE CARRIED OUT UNLESS THE DOCUMENTS HAVE BEEN
AUTHORISED BY THE CLINICAL POLICY GOVERNANCE GROUP**