The Newcastle upon Tyne Hospitals NHS Foundation Trust

Clinical Records Management Policy

Version No.	8
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Ratified by:	Clinical Records Advisory Committee

1 Introduction

1.1 A clinical record is defined as a record consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual. It may be held in a computerised form or in a manual form or a mixture of both.

1.2 This policy seeks to outline the fundamental requirements of sound clinical records management processes in order to ensure that a comprehensive system for the storage and retrieval of clinical records is in place.

1.3 This policy details the specific procedures and responsibilities for the management of clinical records across the Trust and the processes that are in place to ensure the security and safety of the information held.

2 Policy Scope

This policy relates to all clinical records created within the Newcastle upon Tyne Hospitals NHS Foundation Trust and aims to provide a framework for the management of paper and electronic records in order to support the delivery of clinical care.

Management of the clinical record is the responsibility of all Trust staff and is not limited to staff working within Medical Records libraries.

3 Library Structure

3.1 There are 3 main medical records libraries within the Trust and 2 satellite libraries. In addition to these libraries there are local agreed specialised areas where clinical records are held to facilitate groups of patients who are regular or frequent attendees i.e. Transplantation, Psychology; Renal; Women's Services and Paediatrics.

3.2 There is 1 offsite storage facility at Balliol. This houses deceased case notes and stores casualty cards, radiology images, clinical trials and other specialised health records that are required to be retained, in compliance with the NHS retention period guidelines.

3.3 The 3 main medical records libraries are located on the Freeman, RVI and CAV sites. They house both unified and non-unified media types of case notes.

3.4 The satellite libraries are located in the following areas *(see appendix 1 for further information)*:

Dental Medical Records	Located in the Dental Hospital on the RVI site
NCCC Medical Records	Located on the Freeman Hospital site

3.5 Women's Services hold their own specialised ante-natal case notes and house them within the directorate during the patient pregnancy and for a short period of time after delivery. Ante-natal case notes are specialised and not part of the Trust unification process. Baby notes are also held within the directorate for a period of time and are then housed within the main medical records library at the RVI. The women's services directorate management team is responsible for compliance with this policy.

3.6 The Psychology directorate hold their own specialised case notes and are not part of the Trust unification process. The directorate maintains control over these case notes and have a responsibility to comply with the requirements of this policy.

3.7 The Paediatric directorate maintains control over a large number of case notes for children who are regular attendees. The directorate management team is responsible for compliance with this policy.

3.8 The Community directorate Health Visiting/Public Health School Nursing maintain and control for all continuous child health records for all of Newcastle children. These are located in various community health settings across Newcastle. Additionally some records are held in electronic version in accordance with the Clinical Record Keeping Policy. There will only be one contemporaneous record in either electronic or paper based format for each child.

4 Roles and Responsibilities

4.1 **Chief Executive**
The Chief Executive has overall responsibility for all Records Management in the Trust.

4.2 **Caldicott Guardian**
The Medical Director is the Trust's Caldicott Guardian and has lead responsibility at Trust Board level for clinical records management within the organisation.

4.3 **Clinical Records Advisory Committee**
The Clinical Records Advisory Committee is responsible for ensuring that this policy is implemented and that the records management systems and processes are developed, co-ordinated and monitored.

4.4 **Local Record Managers**
Currently the main records libraries are managed as one unit by a departmental manager and the directorate specific libraries are managed by the relevant directorate manager. All departments will conform to the Trust medical records

policy.

4.5 **Library Managers**
Each departmental library / relevant directorate manager has responsibility for the day-to-day supervision of staff and the running of each individual library. Each departmental library / relevant directorate manager is responsible for the provision of all of the monitoring information required by this policy.

Managers who are responsible for the clinical records library and other storage areas where records are kept are required to have current knowledge of, or access to expert advice on the laws and guidelines concerning Confidentiality, Data Protection (including Subject Access Requests), and Freedom of Information.

4.6 **All Staff**
All Trust staff, whether clinical, administrative or supportive, should be provided with appropriate training on induction and beyond to ensure that they are aware of their personal responsibilities in respect of clinical record keeping and clinical records management.

5 Legal Obligations

Trust records are the property of the Secretary of State for Health and must be kept in accordance with the legal and professional obligations set out in the Records Management; NHS Code of Practice in addition to the following legislation and any new guidance affecting records management as it arises.

- The Public Records Act 1958
- The Data Protection Act 1998
- The Freedom of Information Act 2000
- The NHS Confidentiality Code of Practice

This policy is also governed by the following:

- Department of Health and Academy of Royal Colleges Guidance. A clinician's Guide to Record Standards – part 2.NHS information governance standards (2007) and associated legislation.
- Information Governance Alliance Records Management Code of Practice for Health and Social Care (2016)

6 Creation of Clinical Records

6.1 All patients who attend the Trust are registered onto the Patient Administration System (PAS) should have a paper clinical record generated. This paper record will take the form of a paper case note folder; exceptions to this are Emergency Departments where the casualty card/electronic record replaces the case note folder or where the local medical record is to reside entirely within e-Record.

6.2 New Patient Attendees
Following registration of a NEW patient on PAS a 'notes to be made up' media type will be automatically generated within iFit (the trusts electronic records

system). This record should be identified on iFit as a **UNIA** (unified adult record) for **Adult** patients and **TRUST** for children following the agreed process: Creating Casenotes for New Patients

6.3 Patients registered prior to 1st May 2007 may have an existing paper clinical record(s) related to the hospital site(s) of that previous attendance.

Where the patient attends the original site of attendance, this clinical record should be used to record the details of this episode of care. Where the patient attends an alternative site, a further volume of case notes should be created.

6.4 Attendances within the Dental Hospital, NCCC, Women's Services (Ante-natal) and Psychology are supported by an individual clinical record specific to those sites, irrespective of the presence of UNIA/TRUST or other volume of case notes. They are not part of any unified case note.

6.5 Paediatric Oncology Services are supported by a PONCNR clinical record which is used to hold all nursing and results information for children attending this service. Please refer to the Glossary of Clinical Record types which are held in Appendix 2.

6.6 In the event that paper clinical records are held elsewhere for the patient (e.g. Physiotherapy, Palliative care, Fertility services, Genetics) an entry should be made into the main clinical paper record, inside front cover, to inform any user of the source and location of the additional clinical information.

6.7 The Community directorate Health Visiting/Public Health School Nursing will record all new registrations on System-one. A Community database electronic patient record will be generated.

A system for identifying each record destroyed and documenting that the complete file has been scanned electronically as per policy is in place.

6.8 The clinical paper record is currently the main source of patient specific clinical information, within the Trust. Clinical information may also be held electronically and this information should not be replicated within the paper folder. Current electronic systems in use are found in Appendix 3

6.9 Adopted Children

When a child is adopted, he/she will be allocated a new NHS number.

If a child has been registered into the Patient Administration System prior to their adoption and has an existing MRN, the child should be re-registered and allocated a new MRN. The original paper case note should be re-labelled and/or re housed with the new MRN.

All electronic records should be merged into the new MRN. This process should be undertaken by Clinical Informatics staff (as with duplicate records) via the IT helpdesk.

6.10 Patients with Protected Addresses

Should have their address demographics updated to reflect this by displaying

the wording ‘protected address’ as a free text in the address field.
The patients correct (protected) address information is managed by the relevant clinicians’ secretary, where this is securely stored.

6.11 Trans Patients

We understand that people self-identify gender in many ways. We therefore use the term ‘Trans’ as an inclusive term which embraces all gender identities. The characteristic applies to anyone who has proposed, started or completed a process to change his or her sex. There is a new classification of title for transgender patients called Mx which can, if the patient wishes, also be used for those patients in transition. It is unlawful to disclose a patient’s gender history without their consent except in special circumstances. When communicating with other health professionals, gender history need not be revealed unless it is directly relevant to the condition or its likely treatment.

Trans patients can request their gender and names be recorded/updated on the electronic and paper health record to that of their preferred gender and name by making a statutory declaration. Implications of this change mean that their NHS numbers will not be validated through daily traces until such times as a gender reassignment certificate is issued as per the Gender Recognition Act 2004. At this point a new NHS number will be issued and a new record can be created. Information Services will check SCR monthly to see if the patient has been issued with a new NHS number and following discussion with the patient will create a new set of notes transferring records from existing notes as agreed with the patient. Information Services will inform the Medical Records department when this is done.

7. Format of Paper Clinical Records

7.1 Where a paper record is created it should adhere to a uniform format as detailed below.

7.1.1 Folders are a six section design with plastic prongs for securing documents.

7.1.2 Each folder has clear instructions regarding the filing sequence of documents which is printed on the inside front cover.

7.1.3 Each specialty has colour coded clinical sheets (R4B) for ease of identification.

7.1.4 Machine produced recordings, e.g. ECG readings will be securely attached in the relevant section of the folder.

7.1.5 There is a designated place on the cover of the clinical record folder to record anaesthetic hazards and/or allergies.

7.1.6 Each clinical record will have a latest 'year of attendance' identifier to assist in future archiving procedures.

7.1.7 Filing within the clinical record should take place in date order within each individual section.

8. Process for Tracking Clinical Records

8.1 All clinical records associated with an individual patient must be identified on the iFit records tracking system. All clinical records must be tracked out of the original location and tracked into the receiving location in order to confirm receipt of the clinical record.

Notes can be tracked using your PC by entering the patients unique MRN, by scanning the patients MRN code with a wand or smart-badge. Full guidance on tracking can be found using the following link: Tracking Quick Guides

8.2 It is the responsibility of all directorates to ensure that local systems are in place to log any movement of clinical records that occur at any time of the day or week

9. Clinical Records Retrieval and Requests

9.1 Clinical records may only be issued to staff that have a legitimate requirement to access them. Employees may only access their personal clinical record by submitting a Subject Access Request. (Section 12)

9.2 Where clinical records are required for a patient attendance or other clinical requirement, a request must be placed via the iFit Request queue, this request should be actioned by the clinical record holder within 24 hours or the requesting department must be informed of the reason for the delay.

9.3 It is the responsibility of the clinical record holder to transfer the clinical record to the correct location or ensure that the clinical record is in the ward/department where they are required in advance of the scheduled attendance.

9.4 Clinical records required for clinic appointments, should **not** be transferred using the internal postage system, but should be taken to the medical records department. Where the clinical record is located on a different site the trusts courier service must be used. Notes must be placed within a secure transport envelope.

9.5 Additions to clinic must be managed in the following way:

- If the addition is made within 1 week of the scheduled appointment Medical Records must be informed.
- If the addition is made within 48 hours of the scheduled appointment it is the responsibility of the person making the addition to retrieve the notes from the last tracked location.

10. Out of Hours Access to Clinical Records

10.1 RVI /CAV Site
The Medical Records Library at the RVI/CAV site can be contacted on DECT 21619 and staff will assist in the location and retrieval of a record required after normal office working hours. Security staff will assist in the absence of Out of

Hours Medical Records staff.

10.2 Freeman Site
During evenings (until 9pm) and weekends (9am – 9pm), the Admissions Team should be contacted on DECT 39502 for records retrieval. After, 9pm the Charge porter should be contacted.

10.3 Where clinical records are required from other Trusts contact the switchboard of the hospital concerned to request assistance.

11. Non availability of Clinical Records

11.1 When a clinical record is not available for an episode of care, this should be highlighted to the relevant staff in the department that the record was last known to be tracked. The person should be requested to undertake a comprehensive search to locate the record.

11.2 If the record cannot be found in its last tracked location, the Medical Records Library should be contacted as they may be able to locate the record using the RFID technology if the record is tagged.

11.3 If the clinical record remains untraced, a Datix incident form should be completed and a log made of the patient's details.

11.4 A temporary folder can be created by Medical Records for the patient with any relevant clinical information available and this folder should be registered on PAS.

11.5 A weekly check should be made on the case note tracker system to identify any movement of the clinical record, until the record has been located

12. Retention of Records

12.1 Clinical records must be retained for the minimum periods specified in the Information Governance Alliance Records Management Code of Practice for Health and Social Care (2016)

A summary of this guidance pertinent to the Trust's clinical records is detailed below but this list is not conclusive and guidance on individual circumstances should be sought where indicated.

- Adult records must be kept for 8 years after conclusion of treatment or death.
- Paediatric records must be retained until the patient's 25th birthday or 26th if the young person was aged 17 years at conclusion of the treatment or 8 years after death.
- For deceased patients, records should be retained for 8 years after the death of the patient.
- Human fertilisation records, including embryology records as established by HFEA Direction D 1992/1:
    - Where it is known that a birth has resulted from treatment – 25 years after the child's birth.

- Where it is known that no birth has resulted from treatment – 8 years after conclusion of treatment.
- Where the outcome of treatment is unknown – 50 years after the information was first recorded.

- Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies) - 25 years after the birth of the last child.
- Health records for classified persons under medical surveillance - 50 years from the date of the last entry or until age 75 years, whichever is the longer.
- Oncology records should be retained for 30 years. For deceased patients records should be retained for 8 years after death.

13. Disposal and Destruction of Records

Disposal refers to both the destruction of clinical records and the transfer of custody of clinical records. Transfer may include archiving or transfer from one system to another.

13.1 Archiving Process

13.1.1 Archiving refers to the process by which clinical records are scanned using an external bureau and then transferred via a CDROM to a secure Storage Area Network (SAN)

13.1.2 The function is managed by the departmental clinical records manager or their deputy. Departmental library managers will be responsible for the day-to-day operation and maintenance of the system.

13.1.3 Clinical records of live patients who have not attended the relevant hospital within the preceding three years are eligible for archival scanning. In the case of Dermatology clinical records this has been reduced to 2 years.

13.1.4 Stringent checks are required prior to scanning and destruction of the record. These checks should be undertaken by a designated member of medical records staff who will follow the process as described.

13.1.5 Records should be removed from the shelves and the documentation checked to ensure compliance with the retention/destruction criteria. If the archival criteria are met the appropriate archiving media type/indicator will be created in the iFit system and the old media type will be marked as destroyed.

13.1.6 The clinical records are catalogued and securely transported to an external bureau where they are scanned in sequence and the images transferred onto a CD.

13.1.7 An index list of the scanned clinical records contained on the disc will be produced and utilised to check demographical information matches that which is contained within the iFit system and to ensure

that the correct archiving media type has been created.

13.1.8 The CD will be returned to the Trust to be imported onto the SAN using specialist software (Therefore). The original CD will be stored securely within medical records libraries for future reference.

13.1.9 Information Services are responsible for the safe storage of this archived data.

13.2 Retrieval of Scanned Documents

If required, clinical records that have been scanned can be:

13.2.1 Accessed via the medical records library. Where sections of a record are required by the clinician for the consultation these can be emailed in advance of the scheduled appointment.

13.2.2 Out of hours staff at the RVI are trained in the use of the equipment to facilitate access to information that may be required for **emergency cases only.**

14. Destruction of Clinical Records

14.1 The destruction of clinical records without archiving the images should only occur when the legal retention criteria has been fulfilled and must be agreed in advance by the Clinical Records Advisory Committee (CRAC). Applications should be made in writing to the Chairman of CRAC for consideration by the committee.

14.2 Clinical records destroyed prior to November 2009 can be identified from the Trust's Case note Manager System with read only facility available from information services. The following entries indicate that case notes have been destroyed.

FDEST	-	Destroyed Freeman Notes
NDEST	-	Destroyed NGH Notes
RDEST	-	Destroyed RVI Notes
EDEST	-	Destroyed Ophthalmology Notes
SDEST	-	Destroyed Dermatology Notes
ODEST	-	Destroyed NCCT Notes
DDEST	-	Destroyed Dental Notes

14.3 Where records are destroyed after November 2007, an entry should be made in the Trust's Destroyed Clinical Records Database. This can be accessed via the Main Medical Records department.

15. Security of Clinical Records : Storage and Transfer

15.1 All clinical records are held within secure, locked areas inaccessible to the general public. .Access to all clinical records libraries is security controlled.

15.2 Movement of records internally and externally should comply with the Trust's Confidentiality and Security Policy.

15.3 All clinical records should be transported in a suitable sealed container/transport

envelope.

15.4 For transfer of larger volumes of case notes (e.g. for tertiary clinics) the Trust's standard Medical Records Transport Case should be purchased from Supplies Department.

15.5 Paper records should not be left unattended at any time and should never be left in unattended staff cars. Records should not be taken home by staff except in extreme circumstances, e.g. following evening home visits when it may make individuals vulnerable to return to an isolated centre.

If a record which has been taken out of the Trust cannot be securely held at a host site, particularly outside office hours, the record should be transported by taxi or courier to the Main Reception desks on either Freeman or RVI site to be held until collection can be arranged. Records must to be labelled with the final destination required and a contact name and number must be supplied.

16. Transferring Records Internally, within the Trust

16.1 It is the responsibility of the clinical record holder to transfer the case note to the correct location.

16.2 Where practical, the internal postal system should **not** be used for this purpose and the record delivered in person.

16.3 Where the record is required on a separate site, the transfer should be by courier service, or for larger volumes via the portering service. Out of hours, notes urgently needed can be transferred using the blood bikes or if necessary the trusts contracted taxi service but must be transported in a sealed transport envelope.

17. External Transfer (To a non-Trust employee/site)

Trust clinical records that are required by another NHS provider may be transferred where there is a clinical reason to do so. It is preferable to send photocopies of the records but this is not always practical. Transfer of records to an external source should be made either by registered post or by using the trusts contracted taxi service.

17.1 Transfer by Registered Post

Clinical records or copies of clinical records that are required for reasons of patient or legal access or by another Trust should be transported by registered post. Staff are required to hold a record of the postal reference number and confirm receipt of the case notes at the destination within 48 hours of postage.

A. Transfer by Taxi

17.2.1 Clinical records should only be transported using the Trust contract taxi firm.

17.2.2 The taxi driver should collect the patient records from the reception points specified in the contract for each of the Trust's hospital sites (e.g. Freeman Main Reception, RVI Leazes Wing Reception, RVI Peacock Hall, etc.)

17.2.3 The notes must be in sealed container /transport envelope marked "Patient notes - Confidential" provided by the Trust and if not, the driver must decline to take them. (This is included in the Trust Taxi Contract.)

17.2.4 The taxi driver must sign for the records on a form provided by the receptionist.

17.2.5 The taxi driver must deliver the records only to a specified reception point at the addressee's hospital site

17.2.6 The taxi driver must obtain a signature for the delivered records from the receptionist. If this is not possible, he should keep the notes and return them to the consignee point.

17.2.7 All clinical records that are transferred must be tracked on the iFit Tracking System to the external location, detailing the contact telephone number and designation of nominated person who will accept responsibility for the secure storage of the clinical record outside the Trust.

B. Transfer with Clinical Personnel

17.3.1 In some circumstances, it may be necessary for clinical records to be transported with the clinical team. In these instances, the records should be tracked to the individual who will take responsibility for the safe keeping and delivery of the records.

17.3.2 Clinical records should be transported in a suitable sealed container and the process should adhere to Trust's Confidentiality and Security Policy.

C. Transfer of Case Records across site to Archive Storage

17.4.1 Notes identified by the medical records managers for archive from the RVI and FH libraries will be transported to storage facilities at CAV. Notes will be transported using either the trusts contracted courier or by the medical records team in a designated delivery van.

17.4.2 Notes will be tracked using the ifit system to identify they are in transit. Notes will be signed out of the sending library and signed into the receiving library. Notes will then be tracked into a location at the earliest opportunity.

17.4.3 Notes requested that are archived will be sent back to the requesting library as outlined in section 9.2 and above.

18. Training

Case note management training is available to all Trust personnel via the Trust Training Department. This is a 2 hour session that should be booked in advance. Assistance at an individual level can be obtained from the Library Managers at RVI and Freeman sites.

19. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

20. Monitoring Compliance with the Policy

Standard / Process/ Issues	Monitoring and Audit			
	Method	By	Committee	Frequency
Status of case note tracking – to ensure casenote tracker location matches actual physical location of the casenote.	Audit	Medical Records Manager	Clinical Records Advisory Committee	Six Monthly
Process for retaining and disposing of notes	Audit	Medical Records Manager	Clinical Records Advisory Committee	Yearly
Casenote availability	Report Audit	Outpatient Sister Medical Records Manager	Clinical Records Advisory Committee	Daily 6 monthly

21. Consultation and review

The policy changes have been raised at the Clinical Records Advisory Committee.

22. Implementation of Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

Author: Manager, Main Records Library / Chairperson, Clinical Records Advisory Committee.

Appendix 1

Medical Records Storage Areas

Name of Service/Library	Location	Types of Case notes	Access to Library/Service
Cardiothoracic Services	Institute of Transplantation (IOT Basement) Freeman Hospital	Current transplant case notes	Weekday controlled access – Via transplant secretaries, transplant outpatients or Ward 27A Nights/Weekends:- Swipe access only
Cardiothoracic Services	Recipient TX coordinators office, Institute of transplantation Level 4 Freeman Hospital	Active list – patient case notes	Access via transplant coordinators
CAV Medical Records Library	CAV site, building 15 (Basement- Main Office) The start of the CAV library can be located in the basement. Floor plans are visible to assist	CAV stores: Deceased/ Archived case notes Freeman, RVI, ASR, Unified and Non unified active case notes	Swipe access only or ring bell during office hours Weekends/Nights – access via security at CAV
CAV Medical Records Deceased Storage	Estates/Laundry Rm.	Deceased Case notes	Contact Main Medical Records Library at the RVI for assistance
Children's Services	Block 2 L4 CRC RVI	Paediatric Forensic case notes	Swipe access.
Children's Services	Old COPD offices	Paediatric Looked after children case notes (LAC)	Swipe access
Children's Services Paediatric Respiratory	Level 3 Block 1 CRC RVI	Paediatric Respiratory, CF case notes	Swipe access
Children's Services	Level 3 Block 1 CRC RVI	Paediatric Nephrology Patients	Swipe access
Children's Services	Ward 14 Paediatric Oncology RVI	Paediatric Oncology Case notes	Swipe access to Ward 14
Children's Services	Sir James Spence RVI (Basement)	Paediatric Oncology case notes BMT case notes Paediatric Oncology deceased case notes	Swipe access Security to hold key code out of hours/weekends
Children's Services	Paediatric Community Physiotherapy – Level 3 CAV	Paediatric Community Physiotherapy case notes and unified case notes	Swipe access
Children's Services	Paediatric	Paediatric Community	Swipe access

	Community Speech Therapy – Level 3 CAV	Speech Therapy and unified case notes	
Children's Services Storage	Main Medical Records Library RVI (Cabinets)	Looked after children's case notes (LAC)	Swipe access
Children's Services Storage	Balliol Business Park	Deceased Paediatric Oncology case notes	Permission required to access Please contact Jo Fell
Dental Hospital Library	Level 3 Dental Hospital RVI Site	Dental Records stored in Library	Weekday access – Level 3 Dental Hospital Central Records Nights/Weekends – contact security
Dental Storage	Level 2 CAV	Archived Dental X-Rays	Contact Dental Medical Records for access
Dermatology Storage	Level 2 CAV	Dermatology and unified and non-unified deceased case notes	Please contact security at CAV for access or Dermatology Library Manager
Freeman Medical Records Library	Level 2 Freeman Hospital	Library 1:- Freeman case notes and also unified and non-unified case notes	Swipe access Out of hours contact admissions team on extension 39502 or contact security
Freeman Medical Records Library	Level 1 Freeman Hospital	Libraries 2, 3 and 4:- Freeman case notes and also unified and non-unified case notes	Swipe access Out of hours contact admissions team on extension 39502 or contact security
Freeman Medical Records Library	Institute of transplantation (Basement)	Library 5:- Freeman case notes and also unified and non-unified case notes	Swipe access Out of hours contact admissions team on extension 39502 or contact security
Haemophilia Centre	Haemophilia Centre RVI (Filing Cabinets	Unified and non-unified Haematology and Haemophilia Medical Records for current patients	Weekday access – Via Reception at Haemophilia Centre RVI Nights/Weekends:- Swipe access or contact security
NCCC Library	Level 2 NCCC Freeman Hospital Rm: 32.2.625	NCCC Records stored in the Library Haematology – unified and non-unified adult records stored also within the library	Swipe access only.
NCCC Storage	Level 2 CAV	NCCC Deceased Medical Records	Please contact security at CAV for access or NCCC Library Manager
NCCC Storage	NCCC Level 1 (Void)	NCCC Deceased Medical Records	Please contact NCCC Library Manager

NCCC Storage	Balliol Business Park	NCCC Deceased Medical Records	Please contact NCCC Library Manager
Ophthalmology Storage	Level 2 CAV	Ophthalmology Storage	Swipe access Please contact Ophthalmology Medical Records Library Manager or Security CAV
Ophthalmology Storage	Balliol Business Park	Ophthalmology and also unified and non-unified Deceased and Archivable case notes	Please contact Ophthalmology Medical Records Library Manager
Psychology Services	Ward 9 RVI	Psychology case notes only	Please contact Debbie Young
RVI Main Medical Records Library	Leazes Wing RVI	RVI, ASR, Antenatal case notes and also unified and non-unified case notes are stored within the library	Swipe assess Out of hours: - Staff can be contacted on extension 21619 for access to library.
Women's Services	Rm. 620 Ward 35 Level 4 Leazes Wing RVI	Baby notes awaiting follow up/filing of results/Well baby notes	Weekday access – contact 25764 Nights/Weekends – contact 25119
Women's Services Antenatal Clinic	Rm. W2813 Level 4 Leazes Wing RVI	Antenatal Case notes, relating to current pregnant women	Weekday access – contact 25845 Nights/Weekends – contact 25119
Women's Services Postnatal File	Rm. W3601 Level 5 Leazes Wing RVI	Antenatal Case notes for women who have recently delivered	Weekday access – contact 25856 25860 25867 20401 Nights/Weekends – contact 25119
Main Medical Records RVI CAV FH Deceased Storage **Storage pertaining to other areas in the Trust**	Balliol Business Park	Main Medical Records Libraries store deceased case notes. Other areas store case notes that are required to be kept for long periods of time in compliance with the NHS government retention period guidelines	Contact Main Medical Records RVI Contact individual departmental Leads
Restore Offsite Storage Community	Washington (Contact Richard White at CAV Ext 21079)	Community Medical Records are stored	Community areas will access via online digital centre.

Appendix 2 Glossary of Media Types

UNIA	Unified volume for an adult patient (Registration after 2007)
UNIAROM	UNIA volume that has been scanned (archived)
TRUST	Unified volume for a child (Registration after 2007)
TRUSTROM	TRUST volume that has been scanned (archived)
ASR	Adult NGH and RVI notes combined
ASRROM	ASR volume that has been scanned (archived)
UNIC	Child RVI and NGH notes unified stage 1.
UNICROM	Child RVI and NGH unified notes scanned (archived)
UNICF	Child RVI, NGH and Freeman (FH) notes unified stage 2.
UNICFROM	Child RVI, NGH and Freeman (FH) unified notes scanned (archived)
FH	Adult volume, patient attended trust (Freeman) prior 2007
FROM FROMCONA FROMCONL	FH volume scanned (archived) Contaminated FH volume for archiving (archived) Contaminated FH volume for current patients (archived)
RV	Adult volume, patient attended trust (RVI) prior 2007
RROM	RVI volume scanned (archived)
NG	Adult volume, patient attended trust (NGH) prior 2007
NROM	NG volume scanned (archived)
DH	Adult or Child volume. Patient attending Dental Hospital
DHROM	DH volume scanned (archived)
DENTALPKT	Dental documentation only
DHDEST	Dental record destroyed
EYR	Adult or Child volume, patient attended Ophthalmology prior 2007
EYC	Ophthalmology casualty card
ECAS CARD	DO NOT TRACK – Paediatric casualty card held within mermaid
NCCC	Stand-alone volume for Cancer Care patients attending Northern Centre for Cancer Centre (NCCC)
SK	Adult or Child volume, patient attended Dermatology prior 2007
SKROM	SK volume scanned (archived)
SKCROM	Dermatology Casualty cards scanned (archived)
AN	Stand-alone volume for Maternity patients
ANROM	Ante-natal volume scanned (archived)
LIND	Patient attending Lindisfarne unit
LINDROM	Lindisfarne case notes scanned (archived)
FPICU	Freeman Paediatrics ITU Charts [only]
FPICUROM	Freeman Paediatrics ITU Charts scanned (archived)
RITUCHART	Adult and Child RVI ITU Charts
PONCN/R	Paediatric Oncology nursing and results folder
TEMP	Temporary Volume
McMAIN	NOT TO BE USED
NOTES TO BE MADE UP	Patient registered on PM Office but has had no case notes created on the tracker system this message will appear. **Seek advice from Medical Records**

Appendix 3

Electronic systems storing clinical information not replicated in the paper case notes.

Caisis	MSU Letters/Correspondence
Cerner Power chart	Inpatient medication and Investigation Results
Cerner Surginet	Intra-operative Information
Chemo Care	Chemotherapy Prescriptions
Euro King	Birth registrations/Maternity
First Net	Emergency Department Tracking Board and Information system
Medical Photography	Photographs – not always contained within the medical record
Medi-soft	Electronic Patient Record: Cataracts Macula and Diabetics
Mermaid/Diadem 2	Letters and Results Scanned Paediatric Casualty Cards
Mosaiq	Radiotherapy Prescriptions and Planning
System – One	Community Health Information
Therefore	Archived medical records (acute)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **August 2016**

2. **Name of policy / strategy / service**:
Clinical Records Management Policy

3. **Name and designation of Author:**
Mrs Susan Kelly Health Records Manager Mrs Barbara Goodfellow Matron

4. **Names & designations of those involved in the impact analysis screening process:**
L Hall Equality and Diversity Lead

5.

Is this a:	Policy	x	Strategy		Service		
Is this:	New		Revised				
Who is affected	Employees		Service Users		Wider Community		

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
To provide guidance regarding the creation, storage, retention and destruction of Clinical Health Records

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
This policy relates to clinical health records and is in line with current records management guidelines and legislation

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	n/a	no	
Sex (male/ female)	n/a	no	
Religion and Belief	n/a	no	
Sexual orientation including lesbian, gay and bisexual people	n/a	no	
Age	n/a	no	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	n/a		
Gender Re-assignment	Policy in line with Gender recognition Act 2004	No	n/a
Marriage and Civil Partnership	n/a		
Maternity / Pregnancy	n/a		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

no

PART 2

Name:

Barbara Goodfellow

Date of completion:

12.09.2016

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)