Yeovil District Hospital NHS
NHS Foundation Trust

# HEALTH RECORDS MANAGEMENT POLICY

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| Author | Medical Records Manager | | |
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**HEALTH RECORDS MANAGEMENT POLICY**

## 1. RATIONALE

Yeovil District Hospital NHS Foundation Trust is committed to the safe and secure storage of patients' health records and to ensuring they are readily accessible so that good quality and appropriate treatment and care can be given. This is a requirement under the NHS Code of Practice. Furthermore, good record keeping safeguards both patients and professionals from unsafe practice through the mis-recording or misunderstanding of health record information. It is therefore essential that all staff involved with health records take responsibility for their accuracy.

The purpose of the Health Records Management Policy is to build on the guidance contained within the overarching Records Management policy to provide specific guidance relating to records management. The policy defines a structure for the Trust to ensure adequate records are maintained, managed and controlled effectively and meet legal, operational and information needs.

## 2. AIM

The aim of this policy is to:

- Ensure there are clear procedures in place for the creation, management, filing, storage, retrieval and destruction of health records.
- Ensure compliance with Trust policy on confidentiality, access to health records, filing within records and the identification of health records.
- Ensure consistent health record standards are adhered to throughout the Trust.
- Ensure all the records comply with professional standards and those of accreditation bodies, and meet legal obligations.
- Identify the standards that apply when auditing health records in order to monitor and maintain high standards.

## 3. DEFINITIONS

**3.1** **The Health Record:** A comprehensive, standard health record (often known as the case notes) which consists of any information relating to the physical or mental health or condition of an individual which has been made by or on behalf of a health professional in connection with the care of that individual.

3.2 **All Media:** All media refers to health records stored as paper records, electronic records or other storage devices such as CDs.

3.3 **Contemporaneous**: - Occurring in the same time period of time, i.e. writing of notes during or immediately after the care or treatment has been given.

3.4 **Audit**: - A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

3.5 **Patient Administration System (PAS):** PAS is a database which records patient demographic details and details of inpatient stays and outpatient appointments and provides a tracking system for case notes.

## 4. RESPONSIBILITIES

### 4.1 Chief Executive and the Board of Directors

The Chief Executive has overall responsibility and is accountable for the quality of records management with the Trust. The Board of Directors is responsible for ensuring arrangements are in place for managing the quality standards of records management.

### 4.2 The Director of Operations

The Director of Operations is responsible for the overall management of Health Records and for chairing the Records Management Committee.

### 4.3 Medical Director and Director of Nursing and Clinical Governance

The Medical Director and Director of Nursing and Clinical Governance are responsible for promoting and developing a culture where quality health record keeping standards are key to delivering safe patient care.

### 4.4 Divisional Management Teams

The Medical, Divisional and Clinical Directors and Clinical leads, Heads of Departments, Associate Directors of Nursing and Matrons are responsible for ensuring health records stored in all media meet the record keeping standards set out in this policy and are managed in line with the Records Management policy. They must ensure audits are conducted at least quarterly and action is taken against the findings of audits to improve the quality of health records.

### 4.5 Individual Responsibility

All clinical staff are professionally accountable for maintaining the quality of records as defined in this policy. All staff that come into contact with patient information have a personal common law duty of confidence and must maintain records in the format set out in this policy.

### 4.6 Records Management Committee

The Records Management Committee is responsible for ensuring that the records management strategy is implemented and that the health records management systems and processes are developed, coordinated and monitored. Terms of Reference for this group will be held and reviewed annually by the Committee.

### 4.7 Caldicott Guardian

The Trust's Caldicott Guardian is responsible for approving and ensuring that national and local procedures and guidelines on the handling and management of confidential personal information are in place. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

### 4.8 Senior Information Risk Officer (SIRO)

The Trust's SIRO Is responsible for leading and fostering a culture that values, protects and uses information for the success of the organisation and benefit of its patients. The SIRO focuses on the assessment and management of information risk and reports this at Board level, providing briefings and reports on matters of performance, assurance and cultural impact.

The SIRO ensures the organisation has appointed Information Asset Owners (IAOs) who are skilled, focused on the issues and supported.

### 4.9 Information Security Manager

The Trust's Information Security Manager is responsible for ensuring security of all Trust IT systems, data held on them, and the implementation of the Information Security Policy.

### 4.10 Data Protection Officer

The Trust's Data Protection Officer is responsible for ensuring that the Trust complies with the Data Protection Act and acts as a resource for Trust staff.

### 4.11 Health Records Manager

The Health Records Manager is responsible for providing guidance on health records management, for policy review and for the overall development and maintenance of health records management practices throughout the Trust. Responsibilities include maintaining the retention and disposal schedule and managing the off-site medical records department and the clinic prep area in the main hospital.

### 4.12 Information Governance Manager

The Information Governance Manager has a responsibility to ensure that the Trust is able to demonstrate compliance on all associated health record areas. In addition:

- That requests for access to healthcare records is managed appropriately.
- That key indicators for performance on records management are monitored and reported to the Information Governance Group.

### 4.13 Health Records Department

Commonly known as the Medical Records department, it is made up of a Manager, Deputy Manager, Supervisors and full time and part time clerical officers. It is split over two sites with specific responsibilities for the management of records including providing:

- Filing and facilities for storage.
- Systems and processes for the safe handling of case notes.
- Availability of case notes in a timely and organised manner.
- Retrieval of records from off-site storage.
- Scanning, retention and destruction advice.

## 5. LEGAL OBLIGATIONS

All medical records held by the Trust must be processed in accordance with the following Acts of Law:

### 5.1 Data Protection

The Data Protection Act 1998 gives legal rights to individuals in respect of personal data held about them by others. The Act also covers manual records, videos, CCTV, X-Rays and digital photos. The details of the Data Protection Act can be found under the Trust's Policies on the Intranet. The eight Data Protection Principles are:

1. Obtain and process personal data fairly and lawfully.
2. Hold data only for the purposes specified and disclose it only to the people listed in the register entry.
3. Only hold data that is adequate, relevant and not excessive to the purpose for which it is held.
4. Ensure personal data is accurate and where necessary, kept up to date.
5. Hold data for no longer than is necessary.
6. Allow individuals access to information about them and where appropriate correct or erase it.
7. Take security measures to prevent unauthorised or accidental access to, alteration, disclosure or loss and destruction of information.
8. Identify any overseas routine disclosures.

Part II of Schedule 1 of the Act provides a more detailed interpretation of these provisions, which should be consulted as appropriate. Further information about Data Protection is available on http://www.doh.gov.uk/dpa98

5.1.1 The **'Caldicott'** principles surround confidentiality and the protection and use of patient information. The Trust's Caldicott Guardian ensures principles are implemented

locally. Practitioners should ensure they are aware of the Caldicott principles, summarised as:

- Justify the purpose(s) for using confidential information
- Only use it when absolutely necessary
- Use the minimum that is required
- Access should be on a strict need-to-know basis
- Everyone must understand their responsibilities
- Understand and comply with the law

### 5.2 Freedom of Information Act 2000

The Freedom of Information Act (FOIA) creates new rights for individuals and places obligations on public authorities including NHS trusts with respect to recorded information that it holds. These rights and obligations are likely to be more far-reaching and have more impact on public authorities than those created by the Data Protection Act.

### 5.3 Access to Health Records Act 1990

Although patients can formally apply and pay for copies of their records through the Health Records Department, the Data Protection Act 1998, makes provision for patients (and in some cases their representatives) to see their records on a voluntary basis. The spirit of the Act is that patients should have access to the Information held about them.

## 6. Ensuring High Quality Health Record Keeping

### 6.1 Principles of Record Keeping

The primary purpose of the record is to act as a communication tool between health professionals to ensure continuity of care for individual patients. The record's secondary purpose is to act as a record of the decision making process and actions that health professionals have taken in providing that care.

6.1.1 A health record may be kept in any media and is any record which:

- Consists of information relating to the physical or mental health or condition of an individual and which is patient identifiable (including case notes, record cards, videos, x-rays and photographs and integrated care pathways)
- Has been made by or on behalf of a health professional in connection with the care of that individual

6.1.2 The health record will:

- Provide accurate, current, comprehensive and precise information concerning the care and condition of a patient and associated observations
- Provide a record of any problems that arise and any action that has been taken in response to them
- Provide evidence of care required, intervention by healthcare professionals and patient responses
- Include a record of any factors (physical, social, psychological or emotional) that appear to affect the patient
- Record the chronology of event and the reasons for any decisions made
- Support standard setting, quality assessment and audit
- Provide a baseline record against which improvements or deterioration of a patient's condition may be assessed

6.1.3 The importance of the health record in effective record keeping concerns:

- Communicating with others and describing what has been observed or undertaken
- Identifying the role played by those involved in providing or supervising care
- Organising communication and dissemination of information among members of the team caring for the patient
- Demonstrating the chronology of events as they occur in a contemporaneous fashion, the factors observed and the response to care and treatment
- Demonstrating the properly considered clinical decision relating to patient care

### 6.2 Health Care Records Content and Style

The Trust adopts the health record keeping standards based on the guidelines for records and record keeping set out by the Department of Health, Royal College of Physicians and the Nursing and Midwifery Council. It is these standards adopted by the Trust that underpin health records management, refer to **Annex A** and **Appendix A1**.

## 7. MANAGING HEALTH CARE RECORDS

### 7.1 Order of Case notes and Responsibility for Filing

All filing within the case notes should be in the order as set out in **Annex B**.

Documentation created during a patient's treatment and all pathology test results should be filed as soon as possible into the correct location within the case notes after being countersigned by a doctor for all existing pathology results. In the future, the filing of pathology results will not be required as the electronic 'Order Comms' will be used throughout for recording of accessing pathology test results.

It is the responsibility of the current holder of the case notes to ensure that any "loose papers" are filed away in their correct location and that all health records are maintained in a satisfactory and orderly condition.

### 7.2 The Patient Registration Procedure

All new patients are registered onto the Patient Administration System (PAS) by the Registration Clerk within Clinic Prep when they first attend the hospital or via a referral letter. A unique hospital number is generated when the patient is first registered which will be used consistently throughout case notes and other health records stored in all media. In addition, the NHS Number should be used consistently throughout case notes.

The physical creation of case notes is carried out when the patient is first registered; refer to the Patient Registration Procedure and Clinic Prep Registration process in **Annex C.**

Other ways in which an individual can be registered onto hospital systems are as follows:

- **The Emergency Department (ED) Process** - The ED will generate a unique identifying number on the 'Symphony' software system when a patient attends the department. A patient record is created for the attendance using this number; refer to the ED Registration process in **Annex C**.

- **Baby Registration Process** - Babies are registered at birth on the 'Stork' system and a unique hospital number and NHS number is generated on PAS and the baby's details will be recorded in the mother's case notes, refer to the Clinic Prep Baby Registration process in **Annex C**.

- **Radiology Process** – Patients requiring Radiology imaging will be entered onto the Radiology system 'CRIS' which will take patient identifiable details direct from PAS and

the ED software system if the patient is already registered. This system uses the Hospital Number where patients have been registered to identify the images stored on PACS for access by authorised staff. Where patients have not been entered onto PAS, the 'CRIS' system will generate a radiology link number to match up with PAS if the patient is registered in the Trust.

GP request cards will be scanned into the 'CRIS' system.

### 7.2.1 Health Records held by Individual Practitioners or Departments

Any patient notes held by individual practitioners or departments must be held under the unique patient's hospital number and NHS Number where available. The Records Management policy describes the arrangements for holding patients records outside of the main patient record. The Retention and destruction policy applies to records held by individual practitioners / departments.

- Genito-Urinary Medicine (GUM) records are held locally and will not form part of the main patient record.

## 7.3 Duplicate Registrations

If a duplicate registration is identified the records need to be amalgamated. Any duplication of the unique patient identifying number should be reported to the Medical Records Manager who will ensure the duplicates are merged to form one patient ID number and one set of case notes. The Registration Clerk will merge both PAS and paper records.

## 7.4 Incorrect Recording of Information in Health Records

### 7.4.1 Incorrect Demographic Details

Any authorised PAS user identifying incorrect demographic patient information details, either in paper or electronic format must make the correction and ensure the paper and electronic record is updated.

### 7.4.2 Clinical Information Amendments

Where amendments to the health record are required to be made, the rules set out in **Annex D** must be followed.

Where the gender of patients is required to be changed on PAS the procedure and flowchart in **Annex E** must be followed

## 7.5 Confidentiality of Health Records

Particular importance on confidentiality of health records stored in all media is essential for compliance with legal obligations. Reference to the Information Governance and Information Security policies including guidance for sharing information is made under Data Protection Act and Caldicott Principles. Full guidance on confidentiality of health records can be found at **Annex F**.

### 7.5.1 Health Records Library (Artillery Road) – Security Procedure

The objective is to maintain a "closed library" to all but Health Records staff. There are, however a great deal of requests for case notes from other staff groups or individuals, such as Clinical Governance staff, undertaking audits. Those personnel should, therefore, be considered as associated Medical Records staff. In these circumstances, the following policy and procedure should be adhered to (refer to **Annex G**).

### 7.6 Health Record Tracking Procedures

The health record tracking system (application in PAS) ensures the location of every set of case notes is recorded and to make sure they are available for use at every episode of care to eliminate possible clinical risk.
It is the responsibility of every member of staff to ensure that the tracking system is used for every movement of a set of case notes, refer to **Annex H**.

All case notes are the responsibility of the individual or department whilst in their care. Irrespective of the length of time they might be away from the original traced location, **all** movement of case notes must be recorded on PAS. The use of the free text comments box as to the exact location within an office or department is required to aid the retrieval of case notes outside of normal office hours.

### 7.7 Storage and Access to Health Records

Health records are stored in the main off-site records library at Artillery Road but there are other locations where physical records may be stored or held for use, such as:

- Consultant offices or clinic/audit departments
- Off-site storage facilities contractor managed
- Other hospitals (refer to 7.9)

Electronic health records may also be held on software systems. Health records will also be scanned and be held on microfiche.

Procedures for access, transporting health records and off-site storage arrangements including retrieval are set out in **Annex I**.

### 7.8 Obstetric Records

The maternity patients' case note folders will be kept in the Antenatal Clinic (ANC) during the antenatal period unless required for other clinics elsewhere and must be returned to the ANC as soon as possible. During pregnancy the patient carries her own hand-held maternity notes. When the patient has delivered and her hand-held notes are finished with, they must be filed in the main case note folder and returned to the Health Records Library.

### 7.9 Health Records for other Hospitals

Case notes will routinely be made available to the following hospitals:

- Crewkerne Hospital
- South Petherton Hospital
- Verrington Hospital, Wincanton
- Dorset County Hospital
- Yeatman Hospital, Sherborne
- West Mendip Hospital, Glastonbury

Should notes be required by any other hospital then copies should be made; **YDH notes must not be sent**.

### 7.10 Notification on PAS of Death

When a patient dies, the PAS system must be updated immediately to cancel any pending waiting list, outpatient appointments or elective admission.

- If a patient dies whilst in hospital the Ward Clerk will discharge the patient as Deceased.

- Case notes of the deceased patient have a green “DECEASED” sticker placed on the front of the notes by the Ward Clerk or Medical Records staff. Once returned to file the deceased case notes will be filed separately in alphabetical order.

GP Practices notify the Health Records Department of deaths in the community.

## 8. RETENTION AND DISPOSAL OF HEALTH RECORDS

### 8.1 Retention and Disposal of Health Records

Retention of health records in any media is managed under the guidance of this policy. The general retention period is eight years but please refer to the Health Records Retention Schedule on the Trust’s Intranet for exact details on length of retention.

Case notes are disposed of by means of the confidential waste system (refer to the Waste policy) with PAS updated to show notes destroyed. Alternatively destruction will be through contractor approved systems with destruction notices issued and retained by the Health Records Manager.

- Deceased patients’ case notes, if not ready for destruction will be stored offsite at Filofile, Lovington. Each box of deceased patients’ case notes will be bar-coded and cross-referenced against the YDH registration number.

- Retention of x-ray film prior to 2006 when digital systems replaced film is stored at Filofile, Lovington. Files that have been destroyed have been recorded on a Radiology computer system called ‘STALIS’. The ‘PACS’ system which is used to record images is held on site backed up through server at YDH.

### 8.2 Scanning and Destruction Procedure

Case notes pertaining to patients who have been discharged or deceased for less than eight years but more than five years may be scanned on to the Optical Disk Imaging System. This is managed by the records library supervisor and constant “weeding” of notes is done on a weekly basis. Case notes that have been identified for scanning are then boxed and recorded on PAS and sent to an off-site service for scanning. Each box is bar-coded and cross-referenced against the YDH registration number. These case notes will be confidentially destroyed once they have been scanned and appropriate case note “flag” assigned to the registration number on PAS. Data quality checks are carried out on 10% of each batch sent for off-site scanning. Once scanned and quality checked, the notes are disposed of by the scanning company and Certificates of Destruction kept in the Health Records Manager’s office.

#### 8.2.1 Scanning of Emergency Department Case notes

The Emergency Department (ED) will scan and destroy all case notes for patients who have attended the ED at YDH. These scanned notes will be stored onto a server within the Trust accessible to ED staff. Before destruction of the physical case notes takes place a 10% check will be carried out on the scanning by printing and checking quality. The quality of the check should ensure that all details are discernible, only then can the paper record be destroyed. A record of the physical destruction will be kept in the ED and the electronic scanning will be maintained.

## 9. PUBLIC ACCESS TO HEALTH RECORDS

Access to health records in all media by patients and legally authorised bodies must follow strict procedures to ensure confidentiality is maintained for compliance with legal obligations. A fuller description of access procedures can be found at **Annex J**.

## 10. TRAINING AND AWARENESS

Staff training for records management is provided through the following areas:

- Induction training and mandatory training for all staff covers information governance and record keeping.
- Junior Doctors receive training at the start of employment with the Trust.

The Training Needs Analysis identifies the training levels and a record of training is maintained in the Yeovil Academy.

## 11. IMPLEMENTATION, MONITORING AND EVALUATION

This procedure will be implemented, monitored and evaluated in line with the Policy on Procedural documents.

### 11.1 Availability of Records

The medical records manager will twice annually audit health records against this policy to identify availability of records. This audit will report compliance through the records management committee.

There is a process in place to regularly monitor the case notes at Artillery Road for scanning or destruction, guided by Health Records Retention Schedule. This is managed by the Supervisor at Artillery Road and referred to the Medical Records Manager where there is any doubt or conflict.

### 11.2 Quality of Records

Bi-annually a report on findings from health record quality audit reports is to be provided to the Clinical Governance Delivery Committee by the Senior Clinical Governance Assistant for monitoring and review. Resulting action plans will be progressed through divisions.

## 12. APPLICABILITY

This policy applies to all staff employed by the Trust, whether on a permanent or temporary basis.

## 13. REFERENCES

The Department of Health website provides further information on health records management: www.dh.gov.uk

- Records Management: NHS Code of Practice Part 1. (2006)
- Records Management: NHS Code of Practice Part 2. (2nd edition). (2009) Annex D1- Health Records Retention Schedule.
- Confidentiality: NHS Code of Practice. (2003)
- Freedom of Information Act 2000 - www.opsi.gov.uk/acts2000
- Access to Health Records Act 1990 - www.opsi.gov.uk/acts1990
- Data Protection Act 1998 - http://www.doh.gov.uk/dpa98
- Information Security Management: NHS Code of practice. (2007)

The Royal College of Physicians (RCP) website provides further information on record keeping: www.rcplondon.ac.uk

- Generic Medical Record Keeping Standards. (2008)

Nursing and Midwifery Council (NMC). (2009). Record Keeping: Guidance for nurses and midwives. London: NMC. Available at: www.nmc-org.uk

- NMC (2010) Record Keeping Guidance for Nurses and Midwives

- NHS Litigation Authority - CNST Risk Management Standards
- Data Protection Act (1998)

Trust Policies

- Records Management policy
- Clinical Audit Policy
- Information Governance policy
- Information Security Policy
- Safe Haven policy
- Incident Reporting and Investigation policy
- Policy on Procedural Documents

## 14. EQUALITY IMPACT ASSESSMENT

This policy has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and does not discriminate any staff groups. A completed Equality Impact assessment can be found at **Annex K** at the end of this policy.

**Annex A - Health Records Management Policy**

## THE HEALTH RECORD AND STANDARDS

### 1. Introduction

All staff have a personal responsibility to ensure the information they generate is legible, accurate, up to date and accessible. Staff must ensure they are aware of what they are recording and why. The quality of the information can have an impact on the quality of services, care and treatment the Trust provides.

Any information that is stored, produced or recorded on any computer system (including emails) for patients must be printed and added to the paper held health record. For Emergency Department records the documents will be electronically scanned at source and only added to the main case note on subsequent admission to the Trust.

There is a standard patient folder in use throughout the Trust and it incorporates, where possible, the features required by all users.

The folder is clearly identified with

- Unit Number
- Patient's names
- Alert indicators (e.g. allergies)
- Year sticker, which indicates the year the folder was active

There are various coloured borders on the newer case notes that assist the medical records staff to identify miss-files, e.g. a yellow bordered set of case notes filed amongst green borders would be clearly apparent.

The procedure for filing within health records is in accordance with **Annex B** of the Health Records Management policy.

Where there is more than one volume of case notes for a single patient (but with the same unique identifier) each volume should be clearly marked Vol 1 of 2, Vol 2 of 2 etc. Multiple volumes are referred to as Fat Files.

### 2. Standards

There are two areas of health record standards, generic quality standards and professional quality standards. Both of these will be used to determine best practice and monitor the quality of health care records.

As a minimum, the standards require that the health records are clear, legible documents that provide all records of treatment and care history. Entries should be

- Factual, consistent and accurate
- Written clearly, legible and in such a manner that cannot be erased
- Contemporaneous, recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient.
- Accurately dated, timed and signed with the full name printed alongside each entry
- Consecutive
- Bound and stored so that loss of documentation is minimised in accordance with the order set out in Annex B.
- Kept in manageable sized documents

The health record is to be maintained in the case notes as set out in (Standards) Annex A and (Order) Annex B of the Health Records Management Policy.

## 3. Quality Standards

Quality standards refer to the minimum structure and content of the record; for example, the record should be dated and signed. Quality standards have been developed from the standards of accreditation and professional bodies and the literature on health record standards. They form the minimum requirements that are applicable to all health professionals and all health records. All health professionals must maintain these standards (see **Appendix A1**).

## 4. Quality Control

The Trust monitors performance in standards of health record keeping through internal audit through an annual programme. Audit of generic standards, supplemented by appropriate quality standards from professional bodies, is facilitated by the Clinical Governance Audit team. The standards within this policy and those of the Health Records Management policy will be used to establish performance and to identify areas where improvements are required.

The results of audits will be fed back by those conducting the audit through divisional arrangements with the aim of raising the profile of the quality of health records and addressing areas of poor quality through management appraisal.

### 4.1 Midwifery Standards

A midwifery and obstetric record keeping guideline is in place within the maternity services. An annual record keeping audit is conducted with record fed back into the Maternity Risk Management Team in line with Clinical Negligence Scheme for Trusts (CNST) requirements.

**Appendix A1 – Quality Standards for Health Records**

| No | Standard | Criteria | Guidance |
|---|---|---|---|
| 1 | The health records of all health professionals contributing to the care of the patient are accessible. | Health records are available within the area where the patient is being cared for, or health professionals document care in the unit record.<br>Bound and kept in manageable sized documents that are marked consecutively<br>Maintained in file order set out in the Health Records Policy | • The records should be available throughout the 24 hour period.<br>• Where health professionals document care in the unit record this should contain assessment, plans and evaluation as well as documentation of care given. |
| 2 | The health record contains a complete set of identification data | As a minimum the clinical record contains the following patient/clients' identification data:<br>• Unique Identifier (NHS Number / Patient Hospital Number)<br>• Patients Name (in Full)<br>• Address and postcode<br>• Date of birth<br>• Registered general practitioner<br>• Name of admitting consultant/GP where applicable<br>• Patient's/user's telephone number<br>• Sex<br>• Religion<br>• Ethnic group<br>• Occupation/school<br>• Person to notify in an emergency and their telephone number<br>• Source of referral<br>In addition the:<br>• Unique patient/client NHS number or hospital number is on every page and on charts, ECG's, CTG's etc<br>• The patient/client's name is in full on every page and on charts, ECG's, CTG's etc | • The list is a minimum requirement<br>• Identification data must be accessible<br>• The GP full name , address and postcode (Referring GP as applicable) |
| 3 | The health record is contemporaneous. | The record provides a chronological account of the patients/client's care and progress.<br>Entries to the health record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded. | • There should be a logical sequence to the record with entries documented in order of date and time.<br>• Entries must be made as soon after an event as possible. |
| 4 | The health record is legible. | All items in the clinical record are legible and written in permanent photocopyable ink that cannot be erased | • Black ink must be used |

| No | Standard | Criteria | Guidance |
|---|---|---|---|
| 5 | All entries in the health record are dated, timed and signed. | Every entry in the health record should be dated, timed (24-hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alternations should be countersigned.<br><br>The appropriate professional countersigns entries in the clinical record by unqualified staff.<br>Where clinical notes and summaries are typed they are dated and signed by their author | • Personalised stamps are encouraged for use within YDH NHS Foundation Trust alongside a signature. |
| 6 | The health record is maintained in such a way that enhances accuracy. | Ditto marks are not used.<br>Abbreviations may be used as long as the first time that the entry is made it is written in full.<br>Correction fluid is not used. Errors are scored out with a single line, initialled, dated and timed by the person who has made the error. | |
| 7 | Alert notification is completed within the clinical record. | Allergies and reactions are recorded. | • This should be part of the assessment on each admission, if none "none known" should be recorded. |
| 8 | The health record contains all relevant clinical information | As a minimum the health record contains the following:<br>• Assessments<br>• Diagnosis/problems<br>• Treatment/care plans<br>• Investigation/referral (if applicable)<br>• Review/evaluation<br>• Drug therapy record (if applicable) | |
| 9 | The health record includes evidence of patient involvement | This includes details of information given, informed consent obtained and patient/client/carer's preferences.<br><br>Information to support consent, leaflets etc must be recorded. | • There should be frequent entries in the clinical record recording details of verbal or written information given, discussions with the patient/client/carers e.g. following a ward round or change in treatment. |
| 10 | The health record contains transfer and discharge information | As a minimum the record contains transfer and discharge information:<br>• Discharge plan/checklist or referral/transfer forms.<br>• Discharge summary/letter within a time specified locally record of the notification to the general practitioner (including death if appropriate) within a time specified locally. | |

**Annex B - Health Records Management Policy**

## ORDER OF CASE NOTES AND RESPONSIBILITY FOR FILING PROCEDURE

The order of case notes are as follows:

- Labels followed by the front sheet attached to the file spine
- If an Advance Statement (Living Will) exists put this behind the Front Sheet and Labels in a large brown envelope clearly marked “ADVANCE STATEMENT”.

**Section One**

- Clinical History sheets – these should be filed in date order starting with the first episode, most recent episode last.
- The correct way to file – GP letter, A&E sheet or ambulance sheet, then the current clerking
- Operation notes
- Consent Forms
- Discharge Summaries

**Section Two**

- Correspondence, most recent first
  All correspondence relating to patient; Consultant to Consultant; GP to Consultant; information from other hospitals etc.

**Section Three**

- Mount Sheets for results, Haematology, Biochemistry, Microbiology and Radiology
  New mount sheets for each admission, new episode first. Results must be filed in date order and also time order.
- Histology
- Echocardiograms, lung function tests etc.
- ` ECGs
- Audiology Mount Sheets
- Prescription Charts
  These should all be filed in episode order (mount sheets first, prescription charts last).

**Section Four**

- All multi-disciplinary team notes, nursing notes, physio, OT social worker letters etc.

Each specialty history sheet is colour coded

**N.B. Nothing should be inserted in front of the Front Sheet and Labels, which should always be clearly visible.**

When a case note folder needs replacing or separating into volumes, it is the responsibility of the current holder of the medical records to create multiple volumes as follows:

- When a case note folder has reached its capacity, a new case note folder should be opened.
- Start each file as if it is a new file.
- Insert a front sheet and labels in front of the new folder.
- Write on the existing file volume 1 of 2 and the date the first volume ends in top left-hand box.
- Write on the new file – volume 2 of 2 and the start date.

**Annex C - Health Records Management Policy**

## GENERAL PATIENT REGISTRATION PROCEDURE

### 1. Introduction

Any member of staff receiving or clerking patients must make a thorough search of PAS to establish if the patient is registered.

The user must first search PAS by date of birth. If a patient is found with similar details, checks are to be made with other referring details (3 unique identifying details) to select the appropriate patient. Checks can also be made with the referring GP or Dental Practitioner and also by use of the NHS Spine database.

- If a patient is already registered on PAS, the details must be checked and updated as necessary.

- If the patient is not already registered a new registration is made by the Registration Clerk in Clinic Prep. All current patient details must be sent through to Clinic Prep when a hospital number and new set of case notes will be generated, which will include a Front Sheet and Labels.

- When a duplicate registration is suspected the Registration Clerk should be alerted and will then merge the two sets of details carrying out checks against at least 3 unique identifying details. (Lists are provided by IT Support, Taunton, detailing patients that have two (or more) registrations recorded on PAS).

### 2. Clinic Prep Registration Process

Requests for patient registration are received from various sources. These are:

- Access Department
- Medical Secretaries
- Orthopaedic Department
- Emergency Department (A&E)
- Wards
- GP Surgeries
- RMC, Bridgwater

Process of registering a patient with a referral letter on PAS:

- Enter date of birth to ensure patient not already registered. Exit RI screen.
- Enter name of patient without date of birth (this acts as a double check to see if a patient has already been registered under an incorrect date of birth).
- Once you are sure the patient is not already registered on PAS you may begin the full registration process.
- Enter patient details on PAS as prompted, filling in as much detail as possible. A date of birth is always a mandatory requirement to complete the registration process.
- Check details and search for NHS number on the NHS spine (if applicable).
- Issue a hospital number from the next numbered case note folder kept in registration.
- Print front sheet and labels to complete the folder.

NB It is important to remember that patients change names/address frequently

The process listed above applies to all registrations but if registration is done without a referral letter, then the registration clerk will probably have to seek further information and check the details more closely.

## 3. PAS Registration Process for the Emergency Department (A&E)

The following processes apply if the patient is to be admitted to a ward or is likely to be attending an outpatient appointment. If a patient attends the Emergency Department and is discharged the same day with no further appointments, hospital notes will not be required and the record created within ED will be filed within the department local filing system.

If the patient is admitted then case notes are requested by the receptionist and the ED record is amalgamated under the patient's unique hospital number.

The process for registering is as follows:

- Patient arrives in the Emergency Department
- Date of birth and full name is requested by the receptionist
- Date of birth and name details checked on 'Symphony'
- If the patient has no record on Symphony, the PAS system will be checked to see if they have an existing hospital number
- If the patient has no existing hospital number:

    - Between 0900 and 1700 Monday to Friday
      Registration clerk will be phoned with the patient details and the patient will be registered on PAS and issued with a unique hospital number.

    - Out of hours the A & E receptionist will complete a Z form to include all available patient details. The Z forms are picked up by the Registration clerk each morning and patients registered on PAS with a unique hospital number following the Clinic Prep Registration process.

## 4. Clinic Prep – Baby Registration Process

Babies born at Yeovil District Hospital NHS Foundation Trust are to be registered immediately on the STORK maternity system by the delivering midwife.

As soon as baby is delivered all details of birth are entered on STORK.

Within minutes (usually) an NHS and Hospital number is issued to the baby.

All information is automatically transferred to the PAS system.

A hospital folder is not issued at this stage but it is a requirement to record this fact on PAS as follows:

- RI screen, enter hospital number
- At the cursor prompt at the bottom of the screen Press L and enter
- Press N and enter
- Press FT and enter
- Press NFI (no folder issued) and enter
- Enter date and accept

Baby is now registered and all birthing information will be found in the mothers notes for future reference.

If baby needs a hospital appointment in future a case note will be raised and the "no folder issued" flag will be removed from PAS.

**Annex D - Health Records Management Policy**

## PROCESS FOR AMENDING HEALTH RECORDS

### 1. Introduction

Should the patient feel that there is inaccurate information held within the notes, they have a right to ask for it to be amended. Incorrect demographic information will be immediately corrected. If the information is clinical then it will have to be investigated by the Trust before an amendment can be made. The investigation will end in one of the following outcomes:

- The Trust rules that the information is correct and it will not be amended. The patient can appeal to the Information Commissioner for an independent investigation if this happens. The Trust will also agree to a statement from the patient being placed in the notes, which explains their disagreement with the information held therein.

- The Trust agrees what the information is incorrect. However, it is illegal to modify the documentation as it represents “historical information” which could have influenced subsequent events. Therefore a note will be placed in the file which alerts the reader to the inaccuracy and the correct facts. The patient and the Trust will agree the contents of the note.

## PROCEDURE FOR CHANGING THE GENDER OF PATIENTS ON PAS

It is important that the following instructions are adhered to prior to changing the gender of a patient on PAS. Failure to do so may cause problems for the hospital as well as causing the patient undue stress.

**All changes should be co-ordinated by the Manager, Medical Records.**

- If a patient informs a member of staff that they will be changing their gender and subsequently their name, it is in order to enter the new name onto the PAS as an **alias.**

- Entering **Alias** is only a provisional measure until the NHS Spine has been updated with the new NHS number.

- Once the patient details have been changed on the NHS Spine, PAS and casenotes may be amended accordingly. The Registration Officer (ext. 4460) should be contacted immediately (preferably by e-mail). All new details pertaining to the patient should be given as they will have to be checked again the National Spine to ensure that the patient details have been changed and also to find the patient's NHS number (a new number is always allocated).

- Where the patient has an "active" set of casenotes, the Registration officer will be asked to change the patient's casenotes accordingly. A note should be made in the front of the casenotes to "flag" that the patient has changed their gender. It may also be sensible to note the date the change was made. This should alleviate problems and queries in the future.

- The Registration Officer will be asked to confirm (within 24 hours and via e-mail) that the casenotes have been changed accordingly. Any problems locating casenotes must be notified to the Health Records Supervisor (ext. 4961) immediately.

- Once confirmation has been received the Registration Officer will change the patient details on the system. It is suggested that the former name be left as an alias. All correspondence relating to the change must be retained for future reference.

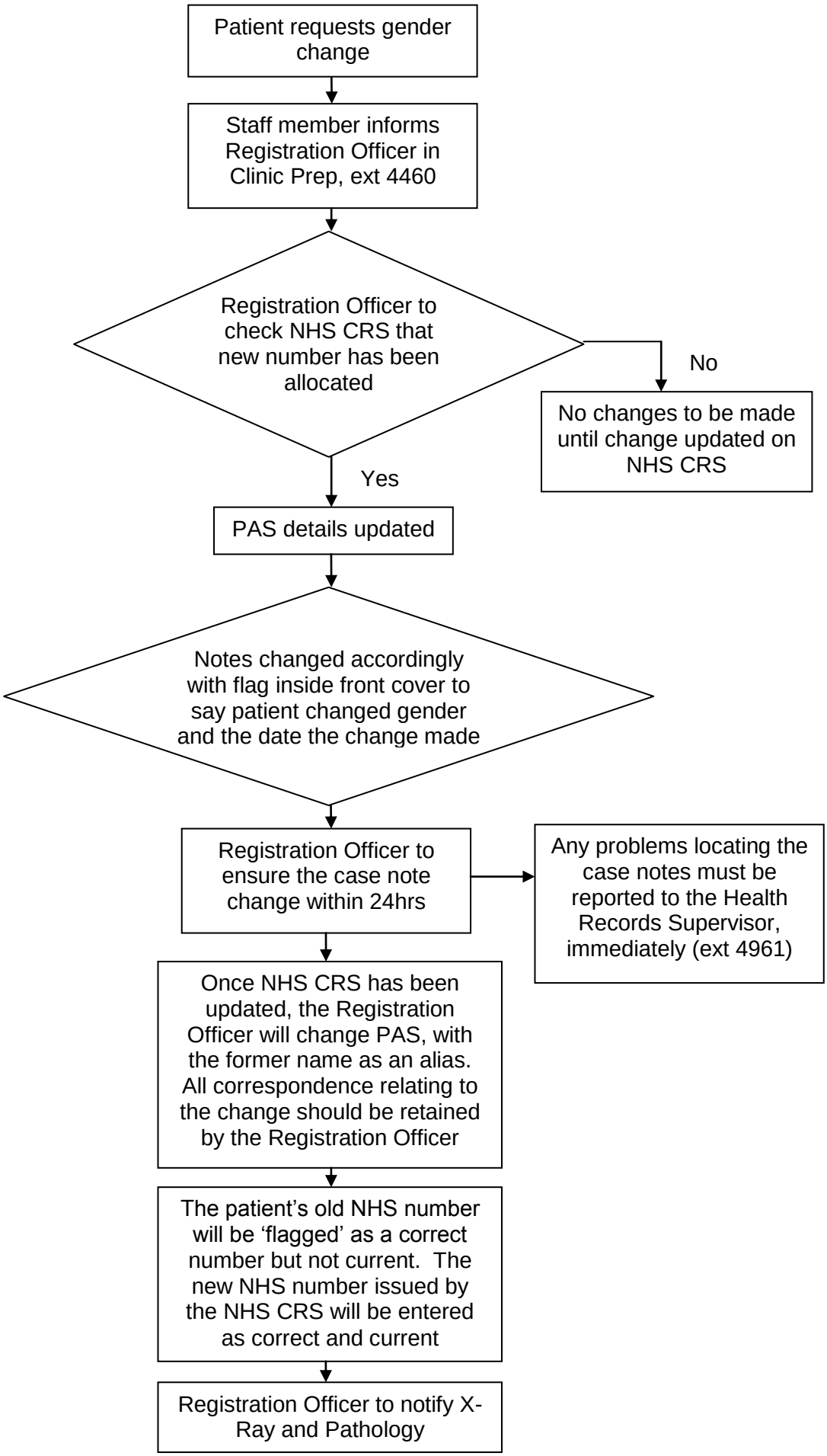
- As part of the change, the patient's old NHS number (if entered) will be "flagged" as a correct number but not current. The NHS Central Register will have issued the patient with a new NHS number; this will be entered onto the system, which will be correct and current.

- The Registration Officer is to inform X-ray Department of the change.

- The Registration Officer is to inform Pathology Department of the change.

The following flowchart shows the overall change process:

# FLOWCHART FOR CHANGING THE GENDER OF PATIENTS ON PAS



**Annex F - Health Records Management Policy**

## CONFIDENTIALITY OF HEALTH RECORDS – INFO FOR STAFF

The following points should be noted to ensure confidentiality is maintained:

- Health records should not be handed over to **ANYONE** unless the identity of that person is confirmed and they are authorised to have access to the information.
- No clinical information should be given to anyone by telephone or personally without the responsible Consultant's permission.
- Basic dates, such as admission and discharge dates may be given to **AUTHORISED BODIES** such as the Department of Social Security. If in any doubt whatsoever about the authenticity of such callers, personnel should take a telephone number and ring back.
- Under **no circumstances** must personnel discuss anything they have seen, read or heard regarding a patient, either with their colleagues or outside the hospital. Any such discussion deemed necessary should only contain the minimum of information required to execute their duties effectively.
- It may be necessary, during the course of duties, to read part of the contents of the Health Record, but this should be limited to as much as is absolutely necessary.
- Health records transferred between departments or other hospitals, either by hand or by the internal post system, must be transported in sealed envelopes. They should only be carried by hospital staff or an approved contractor. Patient identifiable details must not be on show with information kept faced down.
- For health records going externally to other hospitals or healthcare establishments an addressee must be clearly identified and the sealed envelope should be of sufficient strength for transporting and be clearly marked "Private and Confidential. The outer envelope must not contain details of the sender, any details must be included as part of the enclosure.
- Health records and photocopies of records sent via the Royal Mail postal system must be sent by **Recorded Delivery**.
- Health records should not be taken off site unless absolutely necessary, or in accordance with local policy. Copies should be provided in all cases.
- Patients should only carry their own health records when this is thought to be necessary by a Consultant or a member of the health staff. In such cases, they must be sealed in a **new** envelope with the hospital stamp placed on the seal.
- Under no circumstances should personnel discuss personal matters relating to other colleagues unless it is with the clear knowledge and agreement of that person.
- Computer data must remain strictly confidential and should not be in view of **any** unauthorised personnel.
- If personnel are in doubt regarding any aspect of confidentiality or if thy doubt anyone's authorisation to receive medical information, they should check with their immediate line manager or Medical Records Manager.
- Requests from patients for access to their records must be referred to the Medical Records Manager for action.
- Staff are reminded of their obligations under their Terms and Conditions of Employment (Law of Confidentiality), the Data Protection Act 1999 and the Caldicott Committee report.

**Annex G - Health Records Management Policy**

## MEDICAL RECORDS LIBRARY (ARTILLERY ROAD) – SECURITY PROCEDURE

To withhold access to the Health Records Library to anyone not associated with the Health Records function. Staff who will need continued access to the Library include:

- Health Records Library Staff
- Other personnel as authorised by the Health Records Manager, Deputy or Supervisor.

Notes taken from the library **must** be logged onto the tracer system before leaving the filing area.

- The outer door of the library will remain locked at all times.
- Anyone seen entering the library who is not permitted staff will be asked to leave.

### Keypad

The code to the keypad on the entrance door to Artillery Road will be held by authorised staff only. The Training Department on Level 1 of Artillery Road must not issue the keypad number to any staff visiting the building, only staff based at Artillery Road should be privy to the keypad number.

### Windows and Doors at Artillery Road

At the end of each day shift all computers that are not required by the out-of-hours filers or couriers should be switched off and windows closed and any latches secured.

**Annex H - Health Records Management Policy**

## HEALTH RECORDS TRACKING PROCEDURE

The following procedures should be followed:

- The member of staff passing a set of notes to another user must ensure that they log the new location onto the case note tracking system.

- The member of staff passing a set of notes or passing a set onto another user must on no account rely on the recipient logging that movement.

- On receipt of a set of case notes, the receiver should check that the Tracer on PAS is correct and update if necessary.

- The person logged as the holder of the case notes will be held responsible for its safekeeping until such time as they pass the case note on and log that movement and the case note is traced accurately to the recipient.

- Repeated misuse or abuse of the system will result in a reprimand.

**Missing Case Notes and Creating Temporary Case Notes**

- If a case note cannot be found after full reference to the tracer system, this must be reported to the Medical Records Manager or Supervisor.

- Any missing case note will be placed on the missing document file on PAS by the Medical Records Manager or Supervisor. A temporary folder with available records will be created until the missing notes and temporary folder can be amalgamated. Any authorised member of staff can amalgamate the record. The Medical Records manager should be informed when this occurs to remove the note on PAS.

**Annex I - Health Records Management Policy**

# STORAGE AND ACCESS TO HEALTH RECORDS PROCEDURE

## 1. Introduction

Storage, access and transportation / transfer arrangements for health records within YDH and other external locations is outlined in these procedures. The off-site storage location for YDH is at Artillery Road, however there are other contractor managed storage locations on behalf of YDH. Only the external hospital locations set out in 7.9 of the main Health Records Management Policy should hold YDH case notes, if original case notes are found to be held in any other external locations an incident report must be generated.

The physical movement of records should be undertaken in a safe and secure way. Confidentiality of Health Records set out in **Annex E** applies at all times when accessing and transporting / transferring case notes in any format.

The following arrangements for access and transportation are in place:

## 2. Off-site Storage (Artillery Rd), Access and Transportation of Health Records

Access and transportation from Artillery Rd storage will be carried out through the records courier staff. Records can be requested in the following ways:

- **In hours Mon – Fri 8am to 5pm** requests for access made via the medical records staff, case notes will be delivered to Clinic Prep for pick up, or will be delivered by the courier to specific areas. For transport to off-site storage the case notes should be delivered to Clinic prep to be sent back through the medical records courier.

- **Out of hours Mon - Fri 5pm to 8am** through medical records courier (contact mobile phone, available through Switchboard), the case notes will be delivered to the department requesting the notes (case notes will not be required to be transported back to off-site storage during out of hours but should be sent back in hours). **Weekends and Bank Holidays** will be classed as out of hours.

## 3. Access to Health Records from Internal Departments

Case notes can be accessed internally from other departments identified through PAS. Authorised staff should check the Tracer location and request access through the department concerned, collecting the case notes direct ensuring the Tracer system on PAS is updated. Priority access to case notes will be required for clinics and admissions.

Out of hours, access to offices with keypads for access to case notes can be made through the medical records staff or through porters, for offices that are physically locked the Clinical Site Manager will be required to access master keys from Switchboard to gain entry. **Note**: Security staff are not authorised to access health records at any time.

## 4. Access and Transportation / Transfer of Health Records to and from other Healthcare locations

Physical access and transportation / transfer of case notes to and from other healthcare locations must be carried out ensuring that confidentiality is maintained in line with **Annex E** through the arrangements as follows:

- YDH medical records staff transport case notes to other designated hospitals.

- External mail – case notes to other healthcare / hospital locations should be sent by the Royal Mail Special Delivery service, only copies of health records are to be sent

to those hospitals outside the group set out in Section 6.10 of the Health Records Management policy.

- Consultants / Senior Doctors may transport case notes to other hospitals for clinics in private vehicles ensuring that confidentiality is maintained.

- Transferring Ambulances may transport case notes or copies with or without Trust staff ensuring confidentiality is maintained and handover to the patient, escort or driver is carried out. The transfer details should record which health records are being transferred for onward attention, refer to the Transfer of Patients policy.

## 5. Access and Transportation / Transfer of Electronically held Health Records

There are many hospital systems at YDH that hold electronic information on patients. Access to electronically held health records, results, images or other confidential patient information systems will be through authorised user access through training. As part of recruitment procedures staff are provided training and access including removal of access to systems on leaving the Trust.

Any health record data in electronic media may be transported through the following arrangements:

- Health record data scanned onto CD's may be transported to other authorised locations through Royal Mail Special Deliver post ensuring that all data is encrypted, a separate access code sent via alternative means to the addressee should be provided for security.

- Scanned health records or any other patient data may only be sent via secure NHS mail systems, any USB Memory and Data Storage devices must be of the type approved by the Trust (refer to the USB Memory and Data Storage leaflet for on the Intranet).

Under no circumstances should any laptop or similar devices that are used for processing identifiable data should be used for transporting health record information.

## 6. Transporting / Transfer of Confidential Health Record information outside of the Health Record

Health record details that are to be amalgamated with the case notes or to be sent to other healthcare locations or patients may be transported internally or externally ensuring confidentiality is maintained. The following methods may be used:

- **Internal Mail** – Only addressed sealed envelopes must be used.

- **External Post** – Sealed addressed envelopes must be used, first or second class postage applies depending on the time required for the information to be received.

- **Courier Service** – Where contractual arrangements exist couriers may be used.

- **Fax Machines** – For sending confidential patient details to safe haven or patients

- **Email** (with or without attachments) – Emails outside the NHS system should be encrypted (refer to the USB Memory and Data Storage leaflet).

Reference to data security is accessible through the Information Security policy and the Safe Haven policy.

## 7. Archiving and Retrieval of Records

The Trust has off-site storage at Lovington, Castle Cary, Somerset (approximately 20 miles away) where deceased notes are stored. Each box contains a number of patient case notes and each box is bar-coded. The supervisor of the Medical Records Library at Artillery Road manages the collection and retrieval of the deceased notes.

At Artillery Road each time a box is sent for archiving, a list of patients contained within each box is made. The list is put in the box and a bar-code label added to the outside. The supervisor keeps a spreadsheet record so that if notes are needed the exact box bar-code number is known together with the name and hospital number of the notes required. The hospital's PAS tracer system is updated to show that the notes have been archived together with a box number.

When notes are needed a request is made to the storage company (Filofile) via a secure website. The supervisor provides details of the patient number and storage box bar-code number. If notes are not needed urgently they will be delivered within three working days. If notes are needed urgently there is a guaranteed 24-hour service with delivery within two hours.

The Medical Records Library supervisor continuously monitors archived deceased notes from the Lovington store so that those that are no longer required under the guidance of the Retention and Disposal document can be destroyed.

**Annex J - Health Records Management Policy**

# PUBLIC ACCESS TO HEALTH RECORDS PROCEDURES

## 1. Introduction

Requests for notes from solicitors and other legally authorised bodies must be made in writing. Before releasing a health record outside the hospital for reasons other than medical care, the Trust has a duty to ensure the following:

- Written authority to disclosure received from the patient
- Written consent to disclosure received from the consultant in charge of the treatment
- Confirmation obtained that the records will not be used in litigation against the hospital or its employees*
- Written confirmation to undertake responsibility to pay for records received

Requests for notes under the Access to Health Records Act 1990 and the Data Protection Act 1998 must be made in writing to the Health Records Manager.

**Note**: *If there is any doubt about the possibility of a litigation claim against the Trust, requests should be referred to the Clinical Governance Department.

## 2. Access to Health Records

Although patients can formally apply and pay for copies of their records through the Health Records Department, the Data Protection Act 1998, makes provision for patients (and in some cases their representatives) to see their records on a voluntary basis. The spirit of the Act is that patients should have access to the information held about them.

## 3. Informal Request (Health Records)

For patients wishing simply to view their health records, the fees are:

- If the health record has been active in the last forty days then a charge cannot be made.
- If the health record **has not** been accessed in the last forty days then a reasonable charge can be made. The Office of the Information Commissioner considers £10 (maximum) standard charge to be reasonable. Standard photocopying charges per sheet can also be made.
- If the patient (data subject), as a result of viewing their health record, wants a copy of a particular part of it, standard photocopying charges per sheet can be made.

## 4. Formal Request (Health Records)

For patients making a formal subject access request, the fees are:

- For copies of **manual health records** a maximum fee of £50
- For copies of **computerised health records** a maximum fee of £10
- For copies of **both** computerised and manual health records a maximum of £50 may be charged.

The Data Protection Act 1998 allows public bodies 40 days to process a formal request. However, recent guidance from Parliament suggests 21 days as the “gold standard” response time.

Once a request has been received from the patient, the notes will be located and copied. They will be sent to the relevant lead Consultant for their permission to release (see below, Refusal of Access).

## 5. Refusal of Access to Healthcare Records

There are very few cases where access should be refused or limited when patients formally apply for copies of notes. Care should be taken with informal access if there are any concerns that the following might apply:

- When giving access would disclose information likely to cause serious harm to the physical or mental health of the patient or any other individual.

- When giving access would disclose information relating to or provided by a third party who could be identified from that information and who had expected the information to remain confidential.

## 6. Who Else Has Access to Healthcare Records?

Occasionally, persons other than the patient may ask to see the notes. The following have the right of access:

- The patient (refer to Section 5.3 of the Health Records Management policy - Access to Health Records Act 1990).

- Another person authorised by the patient by proxy or other legal documentation.

- The parent or person with parental responsibility for a child under the age of 16 (although the rights of a child must be taken into account and appropriate action taken.

- Where a patient is incapable of managing his/her own affairs, the relevant health professional must judge where giving access to a relative or carer is in the patient's best interests (refer to the guidance provided in the Mental Capacity Act).

Yeovil District Hospital NHS
NHS Foundation Trust

**Annex K – Equality Impact Assessment Tool**

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

Name of Document: **Health Records Management Policy**

| 1. | Does the policy/guidance affect one group less or more favorably than another on the basis of: | **Yes/No/NA** | **Remarks** |
|---|---|---|---|
| | Race | **No** | |
| | Ethnic origins (including gypsies and travellers) | **No** | |
| | Nationality | **No** | |
| | Gender | **No** | |
| | Culture | **No** | |
| | Religion or belief | **No** | |
| | Sexual orientation including lesbian, gay and bisexual people | **No** | |
| | Age | **No** | |
| | Disability | **No** | |
| 2. | Is there any evidence that some groups are affected differently? | **None** | |
| 3. | If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? | **None Identified** | |
| 4. | Is the impact of the policy/guidance likely to be negative? | **No** | |
| 5. | If so can the impact be avoided? | **Not Applicable** | |
| 6. | What alternatives are there to achieving the policy/guidance without the impact? | **Not Applicable** | |
| 7. | Can we reduce the impact by taking different action? | **Not Applicable** | |

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed: **IG Steering Group**
Date: 21 January 2016