Freedom of Information Request - 1651

In your request you asked for the following information: -

1) Does your organization use paper patient records?

2) For which department's or specialisms?

3) Do you record how many patients attend appointments but their file (electronic or paper) is not present?

4) If you do record this information could you provide the statistics for financial year 2012-13 and 2013-14 to date?

5) How are clinicians made aware of clinical records or information held by other departments and specialisms?

6) Are there any metrics for the effectiveness of this measure? Are they routinely published?

7) What time period has to elapse before you declare a clinical record lost?

8) Do any of your risk registers (corporate, departmental or information) contain risks that relate to clinical records? Could you please provide the relevant entry in the register?

9) If you use an electronic patient record system, what system(s) do you use? How many records are included in each system?

10) How do the systems distinguish between active patients (currently under the care of your organization), inactive patients (not under the care of your organization) and the deceased?

11) Do you have a policy or strategic declaration of what constitutes a health record or record in a clinical setting?

In response to the above: -

1) The Trust confirms that it does use paper patient records.

2) The paper patient records cover all departments and specialisms within the Trust.

3) The Trust confirms that all activity of attendances is collected regardless of whether the file is present or not. The Trust does not record the number of patients whose file is not present when attending appointments.

4) As at 30/06/13, the following attendance figures were recorded:

	01/04/12 – 31/03/13	**01/04/13 – 30/06/13**
Outpatient Attendances	298,105	78,275
Inpatient Admissions	38,101	8,925
Day Cases	25,891	6,733
TOTAL	**362,097**	**93,933**

5) There is one set of case notes used for a patient that holds all specialities that they may attend, except for maternity / antenatal who have a separate file but with the same patient reference number used for the general set. Antenatal case notes are prefixed with AN.

6) There are no metrics for the effectiveness of this measure.

7) The Trust does not have a specified time period before declaring a clinical record lost.

8) Incident Reporting (IR1) forms are completed if a set of notes are missing or documents found in wrong notes and the system could collate such data.

9) The Trust does not use an electronic patient record system.

10) Although the Trust does not use an electronic patient record system, it would ask for a retention and destruction to be built into the patient index system to help with retention and destruction and to comply with the Data Protection Act.

11) The Trust confirms that it does have a policy of what constitutes a health record or record in a clinical setting.

Please feel free to contact me if you would like to discuss your request further. If you are not satisfied with this response, you have the right to appeal. In the first instance, please contact the Trust's Governance Manager who will initiate an internal review. The Trust will then review its decision and respond to your appeal, as soon as possible, but within 20 working days. If, following the review, you are still not satisfied with the way we have handled your request, or if you are unhappy with our response, then under Section 50 of the Act, you are entitled to appeal to the Information Commissioner.