Request under Freedom of Information Act 2000

Request Ref: NGFOI 18/19: 253

Thank you for your request for information received at Northampton General Hospital NHS Trust (NGH) on 02/08/2018.

I am pleased to be able to provide you with the following information:

1. *What are the annual number of SARs you processed for the financial years (2016/17, 2015/16, 2014/15)*

   01/04/2016 – 31/03/2017 = 1,648

2. *What are the annual totals (number of SARs) processed that were responded to beyond the 40-calendar day deadline?*

   8

3. *In the last financial year (2016/17) what is the average number of days you have taken to prepare your response to a SAR?*

   68

4. *In the last financial year (2016/17) what was the duration of the longest response to a single SAR?*

   338

5. *What is the total number of SARs you are currently processing?*

   154

6. *Of the total number currently being processed, what is the number that is outside the 40-calendar day deadline*

   30

7. *How many people are involved in the processing of a subject access request?*

   2 – 5 people

8. *How much digital patient data do you retain (to the nearest GB/TB?)*
   1 TB (approx)

9. *Currently, what is the oldest piece of digital patient data you retain?*

Date stamped 2007

10. *In total, how much data do you store a) on-premise and b) in the cloud? (to the nearest GB/TB)*

    On premises 1061TB
    In the cloud None

11. *To the nearest GB/TB, how big was your email archive for the years 2016/17, 2015/16, 2014/15?*

    No archive

12. *Who is the current provider/technology of that archive?*

    N/A

13. *What is your data retention policy around a) patient information and b) medical information?*

    GENERAL HEALTH RECORDS

    Primary documents within an adult general health record comprising correspondence and clinical history should be retained in hardcopy on microfiche or document imaging system for not less than 20 years following conclusion of treatment. Nursing notes will be stored until 8 years after discharge and then destroyed.
    General health records relating to children should be retained for not less than 25 years following conclusion of treatment. However nursing records may be culled and microfilmed/scanned after discharge. Paediatric records may be further culled and microfilmed/scanned prior to conclusion of treatment at the request of the consultant.

    OBSTETRIC folders should be retained in hardcopy form or on microfiche/scanned for not less than 25 years following the last contact.

    ONCOLOGY records should be retained indefinitely.

    HAEMATOLOGY stem cell transplant records should be retained for 30 years minimum, and the UHL-LRI stem cell laboratory contacted prior to discard since records must be kept for a minimum of 30 years after the death of the patient or the destruction/use of cryopreserved stem cells (whichever is the later) – Human Tissue Act 2004.

    DECEASED patient records should be retained for 8 years after the date of death.

    RESEARCH AND DEVELOPMENT DECEASED PATIENT records are retained for 15 years after death or the end of the trial.

    OPERATION LEDGERS and A&E REGISTERS should be retained indefinitely.

    A&E RECORDS. A&E, ENT and EYE CASUALTY records should be retained for 8 years with the exception of those for children, which will be kept until the child is 25 years old, or 8 years after death.

ANCILLARY CLINICAL DOCUMENTS e.g. ITU treatment charts, Scanned?

MENTAL HEALTH records relating to mentally disordered persons within the meaning of Mental Health Act 1983 should be retained for 20 years from the date at which, in the opinion of the doctor concerned, the disorder has ceased or diminished to the point where no further care or treatment is considered necessary.

14. *To the nearest GB/TB, how much unstructured data do you hold?*

13TB

15. *What is your process/method for discovering personally identifiable information?*

Each patient has their own unique number from which we can identify their records.
While the main patient folder is filed in the central Health Records Library during treatment and up to 12 months after that treatment for adults and currently 5 years for maternity and children's records, other subsidiary components of the patient record may be filed electronically or physically elsewhere in Northampton General Hospital.

Most current records are filed in the main medical record folder, depending on where treatment is received within the hospital.

Some departments use an electronic system to store records and this is accessible to the relevant staff; some departments keep their own paper records and securely within that department.

The most frequently used systems for storing medical records (person identifiable information) are checked for each SARs request.

The process of finding records situated outside of the main medical record involves an understanding of the electronic systems used by different departments and which departments hold their own paper records. The patient's episodes of attendance and the main medical record is checked in order to discover whether it is likely that any additional records are held elsewhere.

Certain person identifiable information is not classified as part of the patient's medical record will be kept separately and confidentially as is appropriate. For example occupational health records or complaint paperwork.