

# Scottish Clinical Information Management in Practice

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*'Back Scanning' advice for General Practices*

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# 1 Introduction

## 1.1 Purpose

This document provides advice to General Practices in Scotland on best practice for ‘back-scanning’ patients’ paper records.

## 1.2 Scope and Readership

This document is intended to be used by general practitioners, practice managers, practice IT administrators and GP IT facilitators to assist them in making appropriate business decisions based on their requirements.

## 1.3 Document Summary

All Scottish practices utilise the nationally supplied “PCTI Docman” scanning and document management software to scan, process and subsequently workflow incoming patient correspondence into the NHS Scotland folder structure, creating an Electronic Patient Record (EPR). This record can be electronically transferred to another practice when a patient moves practice, usually with the associated historical paper record being manually transferred via the Practitioner Services Division (PSD) courier system.

This document defines back-scanning in a general practice context, the reasons why a practice may consider back-scanning paper records and the circumstances in which it may be appropriate.

Risks from a medico-legal perspective are considered and aligning any back-scanning project with NHS Scotland eHealth strategies, although at present, no single national specification for back-scanning is in place. Legal admissibility issues regarding admittance of non-original documents into legal proceedings are considered with respect to the BSI Code of Practice<sup>i</sup>, Data Protection<sup>iii</sup>, Scottish GP Contract 2018, possible integrated team requirements and Caldicott Principles<sup>2</sup>, as well as business continuity.

This document also reviews the practical requirements required by Practices in the management of the back-scanning process.

Methods of back scanning are discussed, including contracting with a commercial company or adopting a bespoke in house (DIY) approach. Appropriate formats for record handling, file storage, structuring and storage of scanned documents are outlined.

Although technical aspects are discussed readers should note that this document is not a comprehensive technical review.

## 2 Current Economy

Most practices operate in a 'mixed economy' of paper and electronic records where current clinical notes are recorded on the clinical system and documents from the date the practice implemented scanning and document management are held electronically. The practice will still have a paper record containing clinical notes and correspondence prior to the move to Docman. Patients with a date of birth later than their practice moved to Docman may have no paper record with their EPR being fully held in electronic media.

Currently there is no nationally agreed minimum data standard for an electronically summarised patient record that accurately reflects the information contained in both the paper record and the electronic one. When the practice receives both back-scanned patient records and the original or reproduced paper records, the practice re-summarises the record into a new electronic patient summary that meets the record structure that that practice uses. The practice needs to have a process for comparing and re-summarising the received records (both electronic and paper) and checking any paper records for deletions, annotations and insertions.

SCIMP has a paper<sup>ii</sup> describing how to summarise patients records which we recommend is referred to.

## 3 Back Scanning

### 3.1 Definition

In this context the term 'back-scanning' is used to refer to the process of electronically scanning historical paper documents to create a copy in an electronic file format. In practical terms in a General Practice setting, this means scanning all A4 and Lloyd George paper records that the practice possesses and storing the created electronic images on a computer that the clinicians and staff in the practice can access.

### 3.2 Why back-scan?

#### 3.2.1 To free up space

Space and accommodation issues are important to many practices and one method of releasing space is to back scan and then store the paper records elsewhere. Other methods of managing file space could be considered including:

##### 3.2.1.1 *Records Gardening*

This refers to the process of removing superfluous paper from the records such as duplicates or blank pages and non-medical documents, a process that can be undertaken as part of back-scanning. This process can substantially reduce the thickness of paper volumes but is time consuming and labour intensive.

##### 3.2.1.2 *Changing filing cabinets*

There are a variety of A4 file storage options which may be better suited to your practice's environment than your current method of storage.

##### 3.2.1.3 *Occasional access storage*

It may be possible to free up space by exploring alternative storage arrangements that allow adequate occasional access. For example, some practices working primarily with electronic records have stored their paper records in locations such as a loft or cellar, or in a storage container in the practice car park.

#### 3.2.2 To facilitate full 'paper light' working

Practices operating 'paper light' may find it beneficial to have the whole patient record available electronically, with the advantages this brings to ease of access.

#### 3.2.3 To improve clinical safety

Enabling electronic access to the historical records provides clinical benefit by increasing the amount of information available to clinical staff via their workstations.

Providing the facility to refer to the historical record electronically may provide some reassurance for clinicians anxious about working paper light.

Using OCR (optical character recognition), an electronic document can be searched for any typed term and filtered quickly and accurately (8.4)

#### 3.2.4 To improve business efficiency

It is faster and more efficient to transfer the whole record via Docman transfer than having to retrieve and process additional paper records. This makes the record from the last GP available to the new practice very quickly, improving clinical decision making and safety. It is normally easier and quicker, with resource benefits, to have a medical record completely electronic when responding to a subject access request.

#### 3.2.5 Financial considerations

Practices should consider staff, storage, stationery and any other costs required to maintain a paper record filing system compared to the costs of back-scanning. Consideration also must be given to the process requirements and ongoing costs after the initial back scanning project as new patients join the practice whose paper records will also have to be scanned to maintain the electronic repository. This should particularly be a consideration for those practices considering contracting with a third-party company to back-scan all their paper records as a single project, as there will be an ongoing requirement to handle new incoming paper records once the initial back-scanning project is complete.

#### 3.2.6 Document Storage

Paper records that have been scanned have electronic backups. If the original document is damaged, destroyed or lost then the scanned record will still be available.

#### 3.2.7 Research and Analysis

Properly indexed and searchable scanned documents can provide a useful resource for research purposes and other business analysis.

## **4 Which Practices Should Back Scan?**

For a practice to benefit from back scanning they should first examine their processes with respect to record handling and identify potential problem areas. We would recommend that to obtain the maximum benefit from back scanning a practice should:

### **4.1 Be working paper-light**

'Paper-light' means that in addition to using Docman software as the repository for all patient clinical correspondence, all clinical consultations, visits and messages are being recorded on the clinical computer system and all scheduling (appointments) are electronically managed.

### **4.2 Have a document management policy**

A policy should detail the shredding or destruction of any confidential documents, and all documents which have been scanned during normal day to day processes. There should also be a documented process for backup of computer data and for validating these backups.

### **4.3 Have an adequate IT infrastructure**

Practices should not consider back scanning until their server and network equipment can support the storage, viewing and processing requirements. The IT Facilitators or the Health Board's IT department will be able assess server capacity and to provide advice on whether your practice IT infrastructure is suitable. Remotely hosted servers can improve resilience and will be less vulnerable to damage than a local practice server. This also allows for back-ups to be handled by the hosting service and reduces the risks of limited data storage availability.

### **4.4 Have robust systems and processes**

While generally back scanning should be beneficial, it does introduce new challenges and changes to a practice so risks exacerbating, rather than solving, any pre-existing problems.

## 5 Requirements for Back Scanning

### 5.1 Medico-legal Issues

#### 5.1.1 Integrity

The practice must have a document describing its Practice Information Management Policy which, when combined with supporting evidence that its described procedures are adhered to, needs to demonstrate (for example to a Court of Law) that responsible information management is part of normal business practice.

This Management Policy must be able to demonstrate the integrity of the system either through inclusion of, or by linking to:

- Details of acceptable and unacceptable file formats
- A security and access control policy;
- Standard operating processes and procedures including a system description manual (which would usually be available from the vendor)
- An auditing procedure and documentation of relevant audit outcomes to support the claim that the system is working normally.

Similarly, routine maintenance and replacement of worn parts of the scanning equipment is essential. Practices should be aware and adhere to Health Board procedures for maintenance of both hardware and software used for scanning processes.

#### 5.1.2 Legal Admissibility

The Code of Practice for Legal Admissibility standard provides guidance for users of electronic documents in ensuring their document management procedures are most likely to meet the requirements for acceptance as evidence in a court of law. Although compliance with the Code does not guarantee legal admissibility, it defines best practice. This document has referenced the standard where appropriate and the guidance herein summarises how this may be applied in general practice in Scotland.

A Practice must, at any time and in a manner acceptable to a Court of Law, be able to demonstrate that the contents of a specific data file created or existing with a computer system has not changed since the time of storage and that where that data file is a digitised image of a physical original document, that the digitised image is a true facsimile of the original document.

#### 5.1.3 Authenticity

Electronic images of original paper documents are treated as secondary evidence in a similar way to photocopies. Information must be available regarding when the image was digitised; the format used and the date of destruction of the original document.

#### 5.1.4 Comprehensive and complete

No element of the original paper record should be excluded from the scanning process, although a notes 'gardening' process (as per 3.2.1.1 above) could be undertaken prior to back scanning to remove unnecessary paper from the record.

Notes, such as 'PostIt' or clipped on papers, attached to any document must be included and practices need a process to handle this ensuring that all relevant information is captured and that the relationship between the note and the document that it is attached to is retained.

Non-clinical documentation, for example legal and insurance reports, must be removed from the record prior to scanning and held separately from the clinical record.

Consideration needs to be given to documents that contain third-party information. Although these form part of the record it is advisable to handle them separately from the rest of the document. (See 5.2)

Where a document has physical amendments or annotations, for example, where correction fluid has been used, there should be a process in place to record these, when identified, during the folder and document preparation prior to scanning. Correction fluid may not be evident in any scanned representation of the original thus misleading a reader to think that the scan represents the original state of the paper documentation.

Practices should ensure that A4 record cover sleeves and Lloyd George envelopes are scanned on all sides as part of the scanning process. These will act as identifiers and descriptors of the scanned documents and may also contain important clinical texts such as adverse drug reactions information and other alerts.

#### 5.1.5 Legibility

It is essential that the scanned documents are legible on the computer hardware and software available to the practice. You should aim for a standard of 100% legibility of scanned documents if you intend to either store or destroy the originals in such a way that they will not be readily accessible in the future. To assess this, it is recommended that practices scan and examine an adequate test sample of scanned records to ensure they are legible and no significant meaning or information is lost.

The procedure used for establishing this should be recorded and retained. Such audits should also be repeated at regular intervals to verify ongoing quality. This should be further defined in the practice's Information Management Policy (see Section 9.9.1).

If due to illegibility or quality issues a document needs to be photocopied prior to scanning, it should be annotated on the document that it is a photocopy of the original that is being scanned and not the original. If the photocopy does not improve the legibility or quality issue the practice Data Controller should authorise or directly annotate the document, confirming what the illegible information is and sign and date this as part of their role. This would also have to be part of your documented process. A Practice could have arrangements with the scanning company that the company will increase the DPI (scan quality) of a document with poor legibility.

## 5.2 Data Protection Requirements

Data needs to be stored securely with appropriate access protection, an audit trail to identify who accessed which document, when and any changes made. The practice should have a policy on access control and a system for routine audit of access.

If there is data relating to more than the individual patient in a document, consideration needs to be given to how this information is stored, identified and where required able to be redacted should third-party access be requested.

### **5.3 General Data Protection Regulation (GDPR) and Data Protection Act**

Practices as data controllers must meet the requirements of GDPR and the UK Data Protection Act 2018.

As part of this practices must consider how they process subject access requests under the General Data Protection Regulation 2018<sup>iii</sup>. If the individual's medical record is fully electronic, practices need to consider the costs versus benefits of printing the full document record or providing electronic copy in an appropriate format.

## **6 Business Continuity**

### **6.1 Patient identifiable**

A method of identifying the scanned record as unique to an individual patient is required. In parallel with this, a facility to electronically store scanned documents is required.

### **6.2 Browse functions**

A method of browsing and reading the scanned documents that is acceptable for use in the consulting room should be provided. PCTI Docman document management system and the NHS Scotland folder structure meet this requirement.

### **6.3 Search functions**

Functions to allow users to search for documents, or for key words within documents, adds to the usability of any scanning and archiving system. Where documents are filed appropriately in structured folders as per the NHS Scotland recommended folder names for Docman, and additionally sorted by document 'metadata' such as department and date, the ability of an end user to locate the document they require is increased.

PDF scans that employ Optical Character Recognition will further improve the ability of users to search records for typed text contained within documents. This is not available in TIFF scanned files.

### **6.4 Availability**

The documents should be available to the practice team in the locations and at the times they are needed without having to change location or make an external request for retrieval. Multiple users should be able to access a document for viewing simultaneously.

### **6.5 Secure storage**

As part of Data Controller responsibilities, security processes must be employed to prevent inappropriate access. In addition, a process for auditing access must be in place, routinely undertaken and documented.

In practice many of these requirements can be met using Docman. Docman must be adequately configured with user access rights appropriate to role and use unique user names with passwords for each user in the organisation to allow for audit of access and use.

### **6.6 Backups**

The scanned documents must be backed up as per Health Board protocol. When set up correctly PCTI Docman backs up overnight and provides an error report each morning. The practice must have a system for recording successful back up and reporting of any errors as per the Health Board process. An encrypted verified backup of the original scanned documents taken at the time of scanning would be valuable, should the integrity or authenticity of a document be questioned. If a practice has a hosted server, they must be able to access this same information from the host organisation if needed.

## 7 Processes

### 7.1 Commercial Companies

There are several commercial companies that offer a back-scanning service to general practice. Some of the requirements regarding evaluation and engagement of such a service are outlined below.

#### 7.1.1 Does the company have experience in healthcare?

It is possible that a company proposing to do back scanning for a practice has little or no experience of the healthcare market. The primary health care domain has some specific requirements around document retention, storage and destruction which a company inexperienced in this field may be unaware of.

If the company has previously worked with a local practice it would be useful to ask for a testimonial and the opportunity to visit or discuss the process with them. Similarly, practices should discuss the proposed contract for scanning with their Health Board to ensure it meets any local or national standards and review it against this guidance and associated checklists. If the company is working with other Practices it is essential that there are procedures in place to ensure that patient records from different Practices could not be mixed.

#### 7.1.2 Compliance

Compliance with the Code of Legal Admissibility must be communicated to the commercial company as part of the due diligence process and continued compliance stated as a requirement through inclusion in service contracts.

Practices must also ensure the arrangement they make comply with Scottish NHS SGDHSC CEL 25 (2011)<sup>iv</sup> regarding safeguarding the confidentiality of personal data processed by third party contractors.

Using a commercial company to undertake back scanning does not relieve the Practice from ensuring compliance with the Code. The Practice must be able to demonstrate that the company was compliant at the time of the scanning even if the company has subsequently ceased to trade. The commercial company needs to be able to demonstrate that it has complied with the Code of Practice, for example, processes relating to security and staff references as part of the contractual process. The Compliance Workbook, BIP0009 available from the BSI Shop, can be used to assess the commercial company's environment.

#### 7.1.3 How long will the scanning take?

For a practice to plan they should establish with the company a timeframe for completion of the process, ideally this would be for the supplier to provide. If this is likely to be significant, arrangements should be made to manage the normal practice list turnover and to facilitate retrieval of the paper record at any time whilst it is in the possession of the scanning company.

#### 7.1.4 Staff Time and disruption

Practices need to consider the time and space that will be required by Practice administrative staff to download an inventory from the clinical system, retrieve, pack and cross-check all of the physical paper records to the inventory prior to leaving the practice.

On return, they need to check that all the expected electronic records are received back. This additional work will be required whilst continue the normal daily work of the Practice.

#### 7.1.5 Offsite records

In general, companies will need to remove records offsite to undertake scanning as professional scanning equipment is expensive and difficult to transport. Practices must assure themselves that arrangements are in place for keeping these records secure and undamaged.

When patient records are being held in storage by a scanning company the practice should ensure security procedures and access control systems to this storage are adequate. Storage premises must be dry and secured from theft and unauthorised access.

#### 7.1.6 Confidentiality

The scanning company must ensure that physical access to the patient records is secured, that employees of the scanning company do not deliberately or systematically read the paper records and that, in the event of any data breach, the company will be considered liable. This can be handled in the contract, and is effectively a data processing agreement. The Information Commissioner's office has more detail on the requirements for these, but for this purpose the detail does not need to be extensive.

The scanning company should have in place a process whereby if the scanning company's staff member knows, or is likely to know, any of the individuals whose records are being scanned, that member of staff declares this so that appropriate measures can be put in place to prevent a data breach.

Relevant company policies should be reviewed.

#### 7.1.7 Encryption during transport

Current requirements for the NHS are that no electronic records should be transported un-encrypted.<sup>v</sup> If scanned files are transported to the practice using mobile devices then companies should be able to show that they encrypt the scanned file for transit. If the company uses a centralised server or electronic transfer system, they must be able to show that appropriate security arrangements are in place. This should be described in the contract and will form part of the Data Processing Agreement.

#### 7.1.8 Removal of files

After the scanning process is completed the company must ensure that any copies of documents held on their systems are securely deleted.

#### 7.1.9 Insurance

The practice should ask the scanning company about insurance cover for data loss and third-party liability to cover any risk of data breach or other unforeseen events. The cover should include

protection of the practice from any costs that may arise due to a breach of data responsibilities by the contractor.

## 8 Practical document scanning considerations

### 8.1 Electronic image

Files have many different formats. Commonly used formats include 'TIFF (Tagged Image File Format)' and 'PDF (Portable Document Format)'. Both these formats allow for multiple pages to be stored in a single file, allowing documents of more than one page to be grouped together. Note that TIFF will not support searching on the text within the document, if this has been subject to Optical Character Recognition. (See 8.4)

Ensuring compatibility with Docman is essential as this will enable the scanned files to be transferred using the Docman transfer process<sup>vi</sup>. Both PDF and TIFF are compatible with Docman and would, therefore, be suitable. Note that TIFF in Docman allows for additional annotation such as highlighting but at present PDF documents cannot be annotated. PDF documents can store recognised text and allow for this text to be searched, but this is not possible with TIFF.

Two options for scanning paper records exist – a practice could request that all documents of a type are scanned and grouped together (for example: handwritten notes, clinical letter and labs), or the patient's entire record may be scanned as a single file. For example, pink clinical notes sheets from the Scottish A4 record could reasonably be scanned into a batch, and all letters could be scanned to a separate batch. The aim is to improve usability of the scanned record, thus scanning and filing by document type (however defined) will allow a more granular level of filing to Docman and thus make it easier to browse the record for information required.

Against this a balance needs to be struck with the practical and cost aspects, which tend to favour a single file for the entire record. Scanning companies may provide mitigation for a single file method by providing OCR of typed correspondence, but recognition of handwritten text will not normally be possible and some semi-structured documents, such as laboratory results, may gain only limited extra utility from an OCR process.

If single file scanning is the option selected it is good practice to include separator sheet inserted at the start and end of the file, and individual section sheets between handwritten sheets, tests and correspondence. Detailed on this sheet should be the patients' identifying details including their Unique Patient Identifier (a printed patient label could be used). The number of pages included in the document should be recorded. Information of the scanning process in relation to documents with printing on both sides would need to be obtained from the company, to ensure the correct number of pages is counted. The date, time and name of the person checking the record should also be included.

### 8.2 Document Type Definitions

Practices should consider how they categorise the documents in the patient's record with respect to type when asking the scanning company to scan according to that type. Often a record may be of multiple types, such as Administration or Child Health in the case of child health examinations, or a clinical record as well as a prescription. There are often no easy ways to resolve these

ambiguities, and an acceptance of some maps to type being less precise than hoped for is required. Practices should work with the scanning team by example using some real records to illustrate the document type categorisation required and perhaps resolve some of these ambiguities. The scanning team may wish to seek advice on any significant documents which cannot be easily categorised, or be provided with guidance for filing ill-defined document types.

### **8.3 Colour or Greyscale?**

The practice should consider the 'depth' of scanning for their records. The objective of the scanning needs to be considered. If the objective is to provide a copy comparable with a normal photocopy then 200 to 300 dpi would be acceptable.

Handwriting using a modern ball-point pen a resolution of 200 to 300 dpi would normally be adequate. For older materials, a 400 dpi resolution would be the minimum required.

To assess image quality, it is necessary to compare hard copies of the image and the original.

In general a 'grey scale' scan would be adequate for most purposes. This type of scan will convert colours to an equivalent shade of grey thus maintaining the contrast and allowing documents to be read on the screen. '1 bit' or 'black and white' scanning will lose lighter text and should not be used.

Colour scanning would be ideal and would assist in providing some navigation cues to the scanned file. Unfortunately, scanning in colour will significantly increase file sizes, storage requirements and the time required to complete the process. This may not be compatible with available bandwidth on NHS networks. We would therefore recommend that colour scanning is reserved only for exceptional cases and then only for individual pages or images rather than whole records. Practices are advised to adopt a process whereby the size of the resultant scanned images are kept as small as possible but still retain all relevant information.

Practices should require that the scanning company scans any colour photographs or other images where colour is essential to interpreting the document as a colour scan and do not degrade the image to greyscale.

For most practicable purposes written or printed text can adequately be scanned using greyscale provided advice regarding managing annotations or corrected documents is followed. Practices will need to have processes in place to manage these occasional exceptions.

### **8.4 Character Recognition**

'OCR' stands for 'Optical Character Recognition' and is the process whereby a computer can translate the contents of a scanned document into computable text. The main advantage of this is that it allows the original correspondence to be searched. Additionally, some clinical systems may allow the entire text of the correspondence to be pasted into the clinical record. OCR will only work reliably with typeset documents – handwritten items are not suitable for OCR. Practices will need to instruct the scanning company if they want 'OCR' applied to all documents. Applying OCR to

scanned documents may incur additional cost but is recommended for the additional utility it provides to the scanned records.

'ICR' stands for 'Intelligent Character Recognition'. This term is frequently used when software uses algorithms to recognise patterns associated with "typical" handwritten text. At present we would recommend that this is not used because of the difficulty in reliably distinguishing between handwritten characters and the recognised variable styles and quality of clinicians' handwriting.

## **8.5 Integrate files into Docman**

Scanned historical documents must be linked to the patient's other documents using PCTI Docman, as supplied to all Scottish practices. It may be that the scanning company can provide this service, but it may have to be manually applied by the practice. Scanned documents should be imported into Docman using the National Folder Structure<sup>vii</sup>.

If a single file of the whole paper record is provided it should be stored in the "Historical" folder in Docman with a description of "Electronic copy of historical paper record", this folder correlates with other electronic summaries that have been provided by previous practices with whom the patient has been registered.

## **8.6 Clinical System integration**

Any clinical system approved for use in Scotland is capable of linking to scanned documents stored in Docman. A link is created in the clinical system to the Docman item. This is recommended as it ensures a record of the document exists in the clinical record, which is important for electronic record transfer.

## **8.7 DIY Approach**

SCIMP does not recommend adopting a DIY approach to back scanning many records. Even in a small practice the time required to process, validate and organise the scanned records is likely to be significant.

Where practices are undertaking their own back scanning process they should be able to demonstrate their compliance with the BSI Code of Practice for legal admissability<sup>2</sup>

## **8.8 Funding**

Where specific issues apply such as space constraints or security concerns, agreement may be reached with the Health Board where they are jointly liable, for example where provided accommodation is inadequate for purpose.

Practices may also approach their Health Board to discuss the funding of storage arrangements of records after the back scanning is completed. There is no obligation, however, for Health Boards to fund in part or whole the process of a back scanning project. In cases of disagreement, especially concerning hardware, software or infrastructure support practices should discuss this with their Local Medical Committee.

## 9 Other Considerations

### 9.1 Docman

The key advantages to using Docman for viewing the scanned record lie in the filing 'metadata', the secure logon and the audit trail, thus identifying the document in the context it was added, protecting against inappropriate access and providing a chronology of changes.

The use of Docman ensures that many of the requirements for back scanning in Section 5 above are met. Adding the back scanned file to Docman also allows the complete record to transfer using the Docman transfer process.

Scottish Government Records Management: NHS Code of Practice (2012)<sup>viii</sup> paragraph 48 states: *"Where records are kept in electronic form, wherever possible they should be held within an Electronic Document and Records Management System (EDRMS) which conforms to the standards of the European Union "Model Requirements"."*

PCTI Docman is an EDRMS and thus using it for this purpose conforms to the national guidance.

#### 9.1.1 Docman Folder structure

The nationally agreed folder structure for Docman provides intuitive navigation for filing and retrieval of documents. In most instances it is unlikely that a scanning company will file individual items in the patient's record to specific folders.

Practices could undertake this work after receiving the scanned file, using a software tool which allows extraction of one or more pages from an original document. This may prove to be labour intensive and slow, and is not a recommended approach in light of these practical difficulties. Practices should agree the process they wish to undertake according to their own circumstances, estimate the time and resources required for this work and then plan accordingly. It is important to remember that you may receive records from other practices which are not in the structure that you have agreed and that Practice may have to have processes in place to deal with these situations.

#### 9.1.2 Docman transfer

When a patient transfers out of a practice the Docman Transfer process ensures the back scanned file is transmitted to PSD and thus exchanged with the receiving practice.

If the receiving practice is not within Scotland, PSD need to print out the full electronic record and forward as paper to the receiving practice.

Practices should refer to PSD for advice on acceptable document types for Docman transfer. (0) If Practices use unacceptable file types they are creating a clinical risk on transfer as receiving practices may either not get the document, or lack the knowledge to allow them to view the records.

### 9.2 National Procurement

No national agreement has been reached on an NHS Scotland wide solution to back scanning although this guidance provides recommendations on best practice and in line with legislation and

current and future electronic transfer developments. In some Health Board areas agreement has been reached for back scanning all records supported by and contracted for via the Health Board.

### **9.3 Records Storage**

There are no arrangements for PSD to store paper records, once scanned. Practices would have to make their own arrangements for this. Any arrangement for offsite storage should be agreed with the Health Board. We would recommend that scanned documents are subsequently destroyed rather than retained and stored elsewhere. If the original document is retained it will remain the legally valid document.

### **9.4 Turnover (New registrations)**

The practice will have to put in place a process for back scanning new records as patients with paper records join the practice. They may wish to continue to contract this out to a third party company, or establish procedures in house for handling this. In general we would recommend continuing to employ a third party contractor for this work as this should maintain quality and consistency. Practices will need to decide based on the amount of work and their capacity to meet it.

### **9.5 Retained Paper Records**

Paper records that have not been destroyed would have to be returned to PSD for onward transfer when a patient leaves a practice. There is a risk of disparity between the paper file and the scanned file where the paper file may have been subsequently altered with additions, removals or annotations. For the purposes of Legal Admissibility any changes need to be documented; including the date, time, details of the person making the change and what the change is.

Consequent upon these issues we would advise that the originals of scanned documents should be subsequently destroyed so only a single copy (excluding backups) is retained for operational use.

### **9.6 Back Scanned records in practices not using Docman**

We would recommend that all documents should be transferred into Docman. Printing out previously scanned records creates risks to the integrity of the patient's record with respect to loss of utility, degradation of legibility, loss of original ordering, risks of damage or loss of reproduced records, risk of subsequent annotation to reproduced records, and associated risks on transfer.

The scanned version of the patient's records once the paper copy has been destroyed must be treated as the primary historical record for that patient and it should not be changed or transformed without clear reasons of benefit to individual patient care or administrative procedures, and wherever possible without reducing the integrity or utility of the record.

### **9.7 Cross Border transfers**

Practices should note that approximately 14% of transfers are across the borders from Scotland to other UK nations. Transfers to non-Scottish practices of patient records will generally require that

the scanned documents are printed out before being sent to the receiving practice. Practitioner Services will undertake this task.

Transfers from non-Scottish practices may send documents in a variety of formats including paper Lloyd George cards, paper correspondence, electronic record printouts and occasionally optical media containing scanned documents. There is no single way to handle these documents and each practice must adopt a strategy that meets their requirements. Advice may be sought from PSD or Health Boards.

### 9.7.1 Lost portable data

If a practice received a disk copy of scanned patient records from another practice, they must try to access the information and transfer it into the patients' Docman record. If they cannot access the information they should immediately contact PSD to request additional copies from the previous practice. If it cannot be done, Practices should contact their IT help desk for assistance.

Records on portable media may be considered lost where:

Despite reasonable efforts by the practice no device is available that can read the media

Despite reasonable efforts by the practice the access codes for a password or encryption protected media have not been able to be retrieved

Despite reasonable efforts by the practice the file format of the data on the portable media is now legacy and no currently available software will enable it to be read or converted to a modern format

In this situation the practice, as the current Data Controller, will have to inform the patient about this situation. They should explain that a previous practice has stored some of the patient's records on portable media but that all efforts to access it have been unsuccessful. This may constitute a Data Breach under the DPA and GDPR if the patient is materially affected by the loss of these records. The practice that has identified the issue is not the liable party, however, and by following the guidance herein would be compliant with their responsibilities as Data Controllers. It would not, however, be acceptable simply to destroy the media concerned without informing the patient and/or offering them to the patient for their own use.

Practices should also make efforts to fill in the gaps by direct inquiry with the patient, to mitigate any clinical risks. If after all attempts to fill the gaps have been exhausted and gaps still exist, the Practice should highlight this in the patient's clinical record that there are missing entries in the record and if possible detailing the date range(s). It is suggested that the Read code:

- 9IE.. Incomplete patient record received

is added, and that any known details of the lost data be entered.

## 9.8 Read Coding

Once the digital records are uploaded to Docman Read codes should be added to the clinical system to note that the patient's record is electronic. Suggested codes are:

9346. Total notes on computer

To assist in managing and tracking records, it is suggested that practices tracking use the following read codes:

- 91R.. Patient has no paper record
- 934Z. Computer record NOS

## 9.9 Document destruction and retention

This document references “BIP 0008 Code of Practice for legal admissibility and evidential weight of information stored electronically”**Error! Bookmark not defined.** which contains recommendations on best practice to ensure the legal admissibility of scanned documents. Complying with this guidance can increase the likelihood that such documents will be accepted by a court, but not guarantee it. If original paper records are retained they will continue to be considered the valid copy for legal purposes thus we recommend destruction of the originals.

Good practice dictates that practices, as custodians of the primary care record, ensure it meets the quality required for all its purposes.

Much of the onus of meeting the requirements of the code of practice can be placed on the contracted scanning company and practices should look for guarantees and affirmations that the company they use understands and adheres to its recommendations.

The code of practice aims to ensure documents can be validated as authentic - meaning their origin and content can be trusted; that the integrity of the documents is maintained - meaning that the information conveyed is unchanged; and lastly that the documents are available, defined as ‘accessible as required’. These principles are fundamental to good practice in a health care setting.

To achieve these aims the code of practice advises organisations have the following documentation (and follow the policies and schedules that are defined therein):

- Information management policy document
- Information retention schedule
- Information security policy document
- Procedures manual
- System description manual

In a practice setting these documents do not need to be overly complex – often a single page describing the processes will be adequate. Some documents may already be provided, e.g. the “System description manual” in Scottish general practice is the Docman User Guide accessed from the Docman ‘help’ menu.

### 9.9.1 Information Management Policy Document

An example information policy document is provided in Appendix A. This should be adapted to meet specific circumstances in individual practices.

This document should describe the types of documentation that are included in the scanning processes, describe the file storage methods and media, the auditing and review processes to ensure quality, and name the persons responsible for maintaining the document and ensuring it is adhered to.

### 9.9.2 Information retention schedule

A brief example is provided in Appendix B.

A description of how long the original records are kept for after scanning prior to disposal. The general principles are to ensure that the original has been faithfully reproduced into an electronic format; correctly identified and linked to the patient; and that the copy has been backed up using whatever normal processes the practice has for this. Lastly, before destruction, the backup should be verified i.e. it should be tested that the files can be restored from backup. This document should detail these processes and how they are implemented. The acceptable methods of document destruction used by the practice should be described.

### 9.9.3 Information Security Policy Document

An example is provided in Appendix C.

This document should describe the processes used by the practice to prevent damage, loss or unauthorised access to scanned records. It may detail the security of the practice server room, describe a password and user account policy and outline backup procedures. Procedures on how to act if any security policies have not been met, for example the server room door was left unlocked should also be described. This may be as simple as a sentence stating the practice manager should be informed, or may discuss methods of identifying logged in users from audit trails.

### 9.9.4 Procedures Manual

This document will describe the actual procedures used by staff to manage scanned documents. This will often be a simple step by step description of, for example, the process to be followed to link a scanned document to a patient record in Docman and EMIS or Vision. For back scanning practices should consider and document the processes employed in conjunction with the contractor to ensure staff know and understand how to manage scanned records.

### 9.9.5 Systems Description Manual

Normally in practice these will be the user guides and documentation for Docman and the clinical information system in use, Vision or EMIS.

## 9.10 Document Destruction

Where practices have in place, adhere to and can demonstrate their compliance with these policy documents they may elect to destroy original documents. The responsibility for this decision must lie with the practice as the data controller – authority cannot be granted from external agencies, such as Health Boards or Practitioner Services, as they may have no supervision of the practice's procedures. If the HB is a Joint Controller for the records as defined in GDPR then the practice must discuss the destruction plan with them.

Where practices destroy archived records and do not have in place procedures adhering to the guidance in this document, nor the guidance outlined with respect to the code of practice, they may find their position is indefensible in the event of any dispute.

When paper documents are destroyed, a record of the destruction must be made. This should include a reference for the document, a description of the document and the date of destruction. A 'Disposal Schedule' would constitute the basis of such a record. This means that scanned historical records stored appropriately in Docman should have recorded a date of destruction, and

that this may be recorded as applying to many records rather than individually marked. By storing the record correctly in Docman and including in the scan the original A4 and Lloyd George envelope covers, a reference and description will be implicit.

Duplicate, blank or superfluous items removed during records gardening will not require a formal record of disposal.

Note that no record dated 1948 or earlier should be destroyed. NHS Archivists should be consulted with respect to such records. NHS Archivists should also be consulted prior to document destruction where the record may have a wider historical or medical importance, remembering that on occasion the paper forms themselves may have importance beyond their content.

Where the records are currently subject to any medico-legal processes the originals must not be destroyed or altered until those processes are complete. This does not prevent a practice from scanning them concurrently.

More information on document and records management is available in the Scottish Government Records Management: NHS Code of Practice (2012)<sup>x</sup>. Note that when a record is being scanned it is not being “destroyed” but rather copied to a standard that will allow the original to be destroyed. The record itself is retained, in its new form, and should be kept in line with Annex B of the 2012 code of practice, even if the original is subsequently destroyed.

## Appendix A Information management policy

### Scope

This document describes the information management policy of **Practice Name** with respect to managing patient related documentation, scanning them to Docman and subsequent retention policies prior to destruction.

### Information Covered

This policy describes the management of patient related documents. These may be clinical, administrative, NHS, private or a combination of such types.

Clinical documents include original handwritten records, printed or typed correspondence from or to other health care providers or the patient, printed or typed laboratory, imaging or other results from tests and investigations; forms, annotations, images and any other enclosures relating to clinical care.

Administrative documents will include reports for legal or social security purposes, documents relating to the registration or de-registration of the patient with practices or other services, reports and certificates to third party agencies not providing health or social care.

NHS documents relate to any documentation present that was required or produced for the patient's normal health care from NHS services.

Private documents refer to documents required or produced for non-NHS clinical care.

### Storage Media

Documents will be scanned using Docman to the practice server's hard drives and backups taken to magnetic tape.

### Docman

All documents will be stored in Docman using either PDF or TIFF formats.

### Audits

An audit of 1 record in every 100 will be carried out to ensure legibility and integrity.

### Responsibility

Practice Manager holds overall responsibility for maintaining this policy document and ensuring compliance within the practice.

Staff Member X is responsible for reviewing and checking quality of records as they are imported to Docman.

## **Appendix B      Information Retention Schedule**

### **General principles**

For incoming correspondence scanned to Docman all items will be retained and only destroyed once the backup has been taken and verified.

Documents that are part of records currently under medico-legal review will not be destroyed until such processes are complete.

### **Retention and Disposal**

The practice follows the guidance in the NHS Scotland Records Management policy of 2012.

All patient specific documentation is retained after scanning until a verified backup is created. Sampling audits are carried out to ensure scanned documents maintain their integrity and can be restored from the backup.

Paper records may only be destroyed locally using a cross cut shredder and disposed of securely.

- **or** -

under contract to a confidential clinical waste service as provided by the Health Board (or contracted by the practice).

## Appendix C Information Security Policy Document

### Scope

This document describes procedures for managing users and their access to the clinical and document management computer systems in **practice name**.

### User Management

All users will have unique User Names on all systems requiring a login, specifically Docman and EMIS / Vision.

Usernames will only be active for the period of time the individual is working with the practice. When an individual's role in the practice ends, their user details on all systems should be 'inactivated'.

### Password Management

All passwords must be minimum of 8 characters, contain a combination of upper and lower case characters and numbers.

Passwords are always required to login to practice systems.

Passwords will expire every 90 days requiring a new password to be entered by the user.

### Server Security

The server room will remain locked. The key is available on request from the **staff member** and must be returned after use.

Or e.g. the server is located in office A, and is securely sited. Access to the server for any purpose must be granted by the practice manager. Staff should always consult the practice manager when service or other IT personnel require access.

Remote access to servers and workstations is required for day to day support of systems. Such access must only be granted with the knowledge of the practice manager and only by organisations with a contracted relationship with the practice, or by proxy with the health board.

Remote access by users to practice systems should only be to workstations. Security and login credentials must be agreed beforehand and in keeping with approved Health Board procedures.

### Backup

Servers will be backed up according to the backup schedule elsewhere defined.



## Appendix D Extract from the Docman Transfer Acceptable File Types Standard document – eH4009

### Included file types

The file extensions included below are known acceptable file types for Docman.

Extension	Description	Acceptable	Comment
Rtf	Rich Text	Yes	
Jpg/Jpeg	JPEG Image	Yes	
Bmp	Bitmap Image	Yes	
Txt	Plain Text	Yes	
Csv	Plain Text	Yes	
Pdf	Portable Document Format	Yes	
Tif, Tiff	TIFF (Tagged Image File Format)	Yes (version 6 only)	No way to enforce version check
Mdi	Microsoft Office Document Imaging	Yes	Preferably practices would use TIFF
Doc	Microsoft Office Word 97 or above	Yes (no macros, no mail merge)	No way to enforce macro/mail merge checking
Xls	Microsoft Office Excel 97 or above	Yes (no macros)	No way to enforce macro checking
Htm, html	Web Pages	Yes (no external links/references)	No way to enforce checking of external links/references
Txt, Htm, Msg	Email	Yes (plain text/web pages preferred)	Msg is being copied with places dependency on Microsoft Outlook being installed for all readers
Xps	Microsoft Electronic Document format	Pdf or Tiff format accepted as alternative	Xps

*Table 2: Initial proposed acceptable file types*

Several of these file types include additional notes and guidelines for best practice – enforcement of these guidelines is outside the ability of the currently proposed standard.

## Excluded file types

Any file type not specified above would block export of a patient medical record. Examples include, but are not limited to:

Extension	Description	Comment
Pub	Microsoft Publisher format	Dependent on content, Pdf/Tif/Html suggested as acceptable alternatives
Mht	Web archive	Html format accepted as alternative
Dot	Microsoft Word Document template	Doc format accepted as alternative
Exe	Windows executable file	File contains no clinical content, should not be included
Dll	Windows library file	File contains no clinical content, should not be included
Lnk	Windows shortcut file	Shortcut file should be replaced by target
Shs	Microsoft Office document scrap file	Scrap file should be replaced by MS Office file saved in appropriate format (Doc or Xls)
Url/Http/Ftp	Internet/website address	Dependent on content, Html format accepted as alternative. <b>This format is included in the SCIMP/DfH guidelines.</b>
Zip	Compressed file	Content(s) of compressed archive should be filed individually in patient record
Qrp	QuickReport (GPASS specific)	Pdf or Tiff format accepted as alternative
Avi/Mpg/Mpeg	Movie files	<b>This format is included in the SCIMP/DfH guidelines.</b>
	Proprietary	<b>This format is included in the SCIMP/DfH guidelines.</b>
DICOM	DICOM is a container format that also includes the potential for moving images	<b>This format is included in the SCIMP/DfH guidelines.</b>

**Appendix E**      **Adapted paperwork to manage the back scanning process – reproduced with the permission of NHS Greater Glasgow and Clyde**



**Practice Process Checklist**

<b><u>Date</u></b>	<b><u>Packing and Preparation Tasks</u></b>	
<b>ASAP</b>	Practice manager to confirm the date which the practice will start packing their medical records and also the date which scanned documents should be dated (this date should be pre Docman for the practice) to Project Manager.	<input type="checkbox"/>
<b>Two weeks prior to start date</b>	Project Manager will advise Project Lead, Contractor Services Manager eHealth, of this date to allow review of practice IT infrastructure.	<input type="checkbox"/>
<b>One week prior to start date</b>	Project Manager will also arrange, with the Practice Manager a date & time for an electronic UNIQUE PATIENT IDENTIFIER list inventory to be downloaded. Practice Manager to advise how paper records are currently filed i.e. alphabetically or by date of birth and also whether males and females are filed separately.	<input type="checkbox"/>
<b>On an agreed date</b>	Project Manager will arrange for delivery of packing boxes to the practice, these will be delivered flat packed.	<input type="checkbox"/>
<b>Prior to packing of records commencing</b>	Project Manager will arrange for the supplier to send pre-printed labels to the practice.	<input type="checkbox"/>
<b>On the agreed date</b>	Practice should begin packing records, recording the required information in the electronic inventory. (see attached packing and labelling of boxes process) Practice manager to advise Project Manager of expected completion date for packing. <b>PLEASE NOTE: PRACTICE SHOULD RETAIN RECORDS WHICH ARE CURRENTLY SUBJECT TO MEDICO-LEGAL PROCESSES</b>	<input type="checkbox"/>
<b>N/A</b>	Once the practice has commenced packing the export /return of records to PSD will be temporarily suspended (see attached PSD request for records process)	<input type="checkbox"/>
<b>N/A</b>	Should a practice require access to records once they are with the supplier the urgent retrieval of medical records process should be followed (see attached)	<input type="checkbox"/>
<b>One week prior to uplift</b>	Project Manager to verify uplift date with the supplier and confirm to practice manager.	<input type="checkbox"/>
<b>One week prior to uplift</b>	Practice Manager to ensure that all relevant staff are made aware of the date and details of the uplift and that the records must be made available for uplift on this date. <b>The practice will be invoiced for the cost of the uplift even if no files are available.</b>	<input type="checkbox"/>

	<b>Tasks following Upload of Documents in to Docman</b>	
<b>Test patient file upload</b>	Prior to transfers of electronic files commencing the supplier will carry out a test transfer of 4 files for one patient. Project Manager will provide details of the test patient to the Practice Manager prior to the test transfer.	<input type="checkbox"/>
<b>On-going daily uploads</b>	File any records in Batch Manager that have failed to "Auto file" – the reason for this is highlighted in red at the bottom of the document in the preview pane.  Manage any duplicate patient files if there are active and inactive Docman records	<input type="checkbox"/> <input type="checkbox"/>
<b>Reconciliation Report Analysis</b>	Project Manager will carry out a review of the supplier final summary to agree the number of patient records in the paper record inventory to the number of documents scanned for each patient (including multiple volume records) and uploaded in to Docman.	<input type="checkbox"/>
<b>QA checks</b>	Quality Assurance checks are to be carried out by the practice once files are uploaded to Docman. An agreed selection of the electronic records should be compared to the hard copy of the record which will be returned by the supplier to the practice.	<input type="checkbox"/>
<b>Maximum of 2 weeks later</b>	Once Q & A checks are signed off by the practice Project Manager will contact Health Board or Microtech to request a Tape Verification	<input type="checkbox"/>
<b>Maximum of 2 weeks later</b>	Once reconciliation report has been signed off and the practice has confirmed that QA checks are complete and have signed off the relevant forms Project Manager will arrange for the Senior Partner, Practice Manager to counter sign request for destruction the form and send request to Health Board Caldicott Guardian.  Once approved the supplier will then instruct destruction of the paper records and will forward a copy of the destruction certificate & the supplier's sign off form to the practice.  Project Manager will arrange for confirmation that the electronic records held by the supplier have been securely destroyed following the destruction of the paper records	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

### Process for the packing and labelling of boxes:

- **PRACTICES SHOULD RETAIN RECORDS WHICH ARE CURRENTLY SUBJECT TO MEDICO-LEGAL PROCESSES.**
- Electronic inventory should be updated as records are packed, recording the box number for each record and inserting notes/comments as required e.g. no record, 3 volumes etc. **If a patient has more than one paper record these should be bound together with an elastic band and placed in the same box.** If practice records are stored in a room with no pc it may be possible for Project Lead to lend the practice a laptop for use when updating the inventory.
- To reduce the number of queries from the supplier paper records should be updated as you go to reflect any changes made on the clinical system. Practices should check that the details on the inventory match the details on the front cover of the record and update the comments field on the inventory to note any differences e.g. change of name or amended date of birth. The inventory will be correct as it is produced from your clinical system, but the supplier will need to cross-check the physical file against the inventory so any differences should be noted to assist them.
- Practices should record on the inventory if a paper record is missing or the patient has a fully electronic record, this should be noted in the comments column of the inventory and N inserted into the Paper Rec Y/N column
- There should be NO records in the box which are NOT on the inventory OR records listed on the inventory which are NOT in the box unless there is a comment against the record. **Records should only be packed into a box for currently registered patients**
- Records received at the practice after the electronic inventory has been created should be held and back scanned by the practice (**DO NOT PACK**).
- When practices back scan records there is no requirement to file and workflow the records as with normal mail, the records can be scanned in bulk and filed. Practices should separate the records into four sections: labs (all investigations); clinical notes (all pink sheets); clinical (all letters); admin (everything else, including a photocopy of the front cover of the folder). These bundles can then be scanned and filed in the folder structure, without being work flowed.
- Items which are unsuitable for scanning i.e. CDs, floppy discs, X rays, Lab Samples/ test tubes **must be removed** from the sleeve or wherever they are stored in the record prior to packing . If any of these items are received at the supplier they will be returned to the practice with an inventory at the end of the digitisation process. The practice will be responsible for checking the item/s against the inventory and storing them securely.
- Should you come across records for patients who are no longer registered please return these records to PSD.
- Records should be packed spine down in the box leaving **a gap of 2 cm** in each box.
- Labels containing the practice details and box number are provided by the supplier (see sample label below) a label should be affixed **TO THE END** of each box (**NOT TO THE LID**) :

- Inventory
- Preparation
- Scanning
- Quality Control

## Box: 1

Site Name:

Practice Name:

Practice Number:

- On completion your practice inventory should be retained by the Project Manager and the Supplier contact.
- On receipt of the paper records the supplier will cross check the records against the electronic inventory and will add inventory notes to highlight any issues to the practice i.e. records **added to box** (not on inventory but received by supplier), **records not in box** (on inventory but not received by supplier) and issues with DOB, Unique patient identifier, patient name on paper record not matching inventory.
- Once supplier has finished cross checking inventory it will be returned to the practice via Project Manager who will request that the practice answers any queries. It would be an advantage if the person carrying out this task has experience in the use of Excel and using filters. However Project Manager can provide training if required.

### **Process when patients records are requested by PSD while the record is away for back scanning:**

When a request for a record is received and the notes are either boxed for collection or away to the supplier for scanning, a practice does not need to retrieve the record this can wait until the scanned record is returned to the practice and subsequently to PSD.

As an interim solution the practice undertake a Docman transfer with a full copy of the electronic record from the clinical system and advise PSD that the scanned paper notes will be sent on when returned.

If for any reason a record is urgently required by the requesting practice, the scanning practice will request the records from the supplier by contact the supplier and giving them the following:

- practice details including practice code
- patient's name,
- Unique patient identifier
- Box number recorded in inventory.

Once the back scanned images are up loaded into Docman, the practice has carried out their Q&A and signed off the back scanned images they can then carry out the deduction and export process.

### **Reconciliation & Quality Assurance**

On completion of upload of electronic files to a practice, the supplier will provide a reconciliation report. This is an additional step in the process which will provide confirmation that all records received at the supplier have been digitised, transferred to the practices.

Anomalies will be raised with the supplier. The supplier should return a pre agreed number of records to the practice to allow the practice to check the paper records against the electronic version any anomalies should be reported to Project Manager.

The practice manager should advise Project Manager when QA checks are complete and they are happy to sign off the QA process.

### **Tape Verification**

Once the QA process is complete the Practice Manager should contact the Health Board/ Microtech to arrange for an interim tape validation.

### **Record Destruction Sign off**

There are two forms to be completed and sent to Project Manager to sign off the paper records for destruction (examples of both forms are attached):

- Destruction of Historic GP Health Records Checklist Appendix B
- Risk Assessment, Medical Records Back Scanning Completion.

Project Manager will then arrange for the Data Controller to counter sign the Destruction of Historic GP Health Records Checklist Appendix B and return to the practice along with the supplier Certificate of Destruction.

**Destruction of Historic GP Health Records Checklist**

**Name of Practice:**

**CH(C) P:**

**Address:**

**Practice Code:**

The above Practice requests approval from the Caldicott Guardian, (Health Board Name) to securely destroy the historic GP health records. We confirm that we have taken the following steps to ensure that these records have been reproduced in an accurate and complete electronic copy of the original paper records.

1. The scanning of our historic GP records has been completed by the approved contractor on..... (date).  
A Risk Assessment has been carried out and this is attached.
2. A random sample of the back scanned records were checked with no errors or omissions evidenced.
3. All files have been imported into Docman and a Tape verification of Docman database has been completed .....(date).
4. The Practice computer system is fit for purpose and meets SEF requirements.
5. There is a signed support contract funded by NHS Greater Glasgow & Clyde and a Disaster Recovery Plan is in place.
6. The practice has IT recovery arrangements with back-ups being verified and securely stored off-site.
7. The practice has in place a security policy that complies with current good practice.
8. The computer system security measures and audit functions are enabled and **will not** be disabled.
9. The server has enough spare capacity to handle the envisaged increase in network traffic.
10. All GPs in the practice are aware of and undertake to have regard to the Good Practice Guidelines for General Practice Electronic Patient Records v3 (Scottish Revision Version 1.0), prepared by the Joint Computing Group of the General Practitioners Committee and the Royal College of General Practitioners (sponsored by the Department of Health).
11. Training and education with regard to having full access to computer based records has taken place in-practice.
12. Staff have received Information Governance/Data Protection training.
13. Once approved for destruction the records will be destroyed by The supplier the approved contractor on .....(date)
14. We confirm that we are registered with the Information Commissioner (Data Protection Act 1998) as ..... (name), Registration Number .....
15. Auditing of the records system will be permitted by the practice to evidence our compliance with these statements if required.
16. We comply with the CIA principles of Information Security -
  - CONFIDENTIALITY of all data
  - INTEGRITY of all data and -
  - AVAILABILITY of all data.

**On behalf of the Practice**

Signed Senior Partner/Data Controller .....

Date .....

Signed Practice Manager .....

Date .....

Signed Project Manager .....

Date .....

## Risk Assessment Medical Records Back Scanning Completion

Practice Name:

Practice Code:

Completed by (please print name):

Practice Manager/ Senior Receptionist (please circle as appropriate)

Date inventory signed off and sent to The supplier / /

Date back scanning uploads commenced: / /

Date back scanning uploads completed: / /

	Risk Assessments completed:	Please tick √
1	Records which failed to auto file reviewed	Satisfied with image detail & content
2	Overview of back scanned records	Satisfied with image detail & content
3	SFR /EFR process used YES/NO (delete as applicable )	If YES satisfied with image detail & content
4	Paper Records returned to practice for QA checks : YES (please tick) <input type="checkbox"/> Nos of records <input type="checkbox"/>	Satisfied with image detail & content
5	Original documents /media unsuitable for back scanning received YES/NO (delete as applicable )	If YES practice have recorded and saved this information
6	It has been confirmed to me that a Reconciliation Report has been received & validated by NHSGG&C	
7	Practice sign off closure of back scanning process	

**Signed :**

**Date:**

## References

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- <sup>i</sup> BS 10008:2008 Evidential weight and legal admissibility of electronic information.  
<http://shop.bsigroup.com/>
- <sup>ii</sup> SCIMP Summarising Medical Records  
<http://www.scimp.scot.nhs.uk/guidance/summarising-medical-records/>
- <sup>iii</sup> General Data Protection Regulations 2018-01-31  
<https://www.eugdpr.org/>
- <sup>iv</sup> CEL 25 (2011) SAFEGUARDING THE CONFIDENTIALITY OF PERSONAL DATA PROCESSED BY THIRD PARTY CONTRACTORS  
[http://www.sehd.scot.nhs.uk/mels/CEL2011\\_25.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2011_25.pdf)
- <sup>iv</sup> CEL 25 (2012) NHSSCOTLAND MOBILE DATA PROTECTION STANDARD  
[http://www.sehd.scot.nhs.uk/mels/CEL2012\\_25.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_25.pdf)
- <sup>v</sup> MR002 Docman Transfer Project Docman Transfer Process – GP Guidelines  
<http://www.psd.scot.nhs.uk/professionals/medical/guidance.html#medrec>
- <sup>viii</sup> Docman Folder Structure  
[http://www.scimp-wp.scot.nhs.uk/wp-content/uploads/documents/Procedures-DocmanDocumentFoldersv2.3\\_2011update.pdf](http://www.scimp-wp.scot.nhs.uk/wp-content/uploads/documents/Procedures-DocmanDocumentFoldersv2.3_2011update.pdf)
- <sup>viii</sup> Scottish Government Records Management: NHS Code Of Practice (Scotland) Version 2.1 January 2012  
<http://www.scotland.gov.uk/Publications/2012/01/10143104/0>
- <sup>viii</sup> The 2018 GMS Contract in Scotland  
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