

SCHEDULE 1

Regulation 6

Information to be included in the Statement of Purpose

1. The aims and objectives of the establishment or agency.
2. The name, address, telephone, fax and electronic mail contact details (if any) of the registered provider and of any registered manager.
3. The relevant qualifications and relevant experience of the registered provider and any registered manager.
4. In the case of an organisation, details of the responsible individual's roles and responsibilities within the organisation.
5. The number, relevant qualifications and experience of the staff working in the establishment or for the purposes of the agency.
6. The registered provider's organisational structure.
7. The kinds of treatment, facilities and all other services provided for in or for the purposes of the establishment or agency, including details of the range of needs which those services are intended to meet and which are available for the benefit of patients.
8. The arrangements made for seeking patients' views about the quality of services provided by the establishment or agency.
9. The arrangements made for contact between any in-patients and their relatives, friends and representatives including any limitations on visiting hours.
10. The arrangements for dealing with complaints as set out in regulation 24.
11. The arrangements for respecting the privacy and dignity of patients.
12. The date the statement of purpose was written and, where revised in accordance with regulation 8(a), the date of such revision.

SCHEDULE 2

Regulations 10(3), 12(2) and 21(2)

Information required in respect of persons seeking to carry on, manage or work at an establishment or agency

1. Positive proof of identity including a recent photograph.
2. Either—
 - (a) where the certificate is required for a purpose related to registration under Part 2 of the Act or the position falls within regulation 5A of the Police Act 1997 (Criminal Records) Regulations 2002, an enhanced criminal record certificate issued under section 113B of the Police Act 1997⁽¹⁾ which includes, as applicable, suitability information relating to vulnerable adults (within the meaning of section 113BB(2) of that Act) or suitability information relating to children (within the meaning of section 113BA(2) of that Act) or both, in respect of which less than three years have elapsed since it was issued; or
 - (b) in any other case, a criminal record certificate issued under section 113A of the Police Act 1997 in respect of which less than three years have elapsed since it was issued,and references to the Police Act 1997 include references to that Act as amended from time to time.

(1) 1997 c. 50.

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3. Either—

- (a) where the certificate is required for a purpose related to registration under Part 2 of the Act or the position falls within regulation 5A of the Police Act 1997 (Criminal Records) Regulations 2002, an enhanced criminal record certificate issued under section 113B of the Police Act 1997 which includes, as applicable, suitability information relating to vulnerable adults (within the meaning of section 113BB(2) of that Act) or suitability information relating to children (within the meaning of section 113BA(2) of that Act); or
- (b) in any other case, a criminal record certificate issued under section 113A of the Police Act 1997,

and references to the Police Act 1997 include references to that Act as amended from time to time.

4. Written references from each of the person’s two most recent employers.

5. Where a person has previously worked in a position which involved work with children or vulnerable adults, verification, so far as reasonably practicable, of the reason why the employment or position ended.

6. Documentary evidence of any relevant qualification.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. Where the person is a health care professional, details of the person’s registration with the body (if any) responsible for regulation of members of the health care profession in question.

SCHEDULE 3

Regulation 23(1), (3)

PART 1

Period for which Medical Records must be Retained

Type of patient	Minimum period of retention
(a) (a) Patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded	Until the patient’s 25th birthday
(b) (b) Patient who was aged 17 at the date on which the treatment to which the records refers was concluded	Until the patient’s 26th birthday
(c) (c) Patient who died before attaining the age of 18	A period of 8 years beginning on the date of patient’s death
(d) (d) Patient who was treated for mental disorder during the period to which the records refer	A period of 20 years beginning on the date of the last entry in the record
(e) (e) Patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving that treatment	A period of 8 years beginning on the date of the patient’s death

Type of patient	Minimum period of retention
(f) (f) Patient whose records relate to treatment by a general practitioner	A period of 10 years beginning on the date of the last entry in the record
(g) (g) Patient who has received an organ transplant the earlier	A period of 11 years beginning on the date of the patient's death or discharge whichever is
(h) (h) Patients involved in clinical trials	A period of 15 years beginning with the date of conclusion of treatment
(i) (i) All other cases	A period of 8 years beginning on the date of the last entry in the record

PART 11

Records to be Maintained for Inspection

1. A register of patients, including—
 - (a) the name, address, telephone number, date of birth and marital status or civil partnership status of each patient;
 - (b) the name, address and telephone number of the patient's next of kin or any person authorised by the patient to act on the patient's behalf;
 - (c) the name, address and telephone number of the patient's general practitioner;
 - (d) where the patient is a child, the name and address of the school which the child attends or attended before admission to an establishment;
 - (e) where a patient has been received into guardianship under the Mental Health Act 1983, the name, address and telephone number of the guardian;
 - (f) the name and address of any body which arranged the patient's admission or treatment;
 - (g) the date on which the patient was admitted to an establishment or first received treatment provided for the purposes of an establishment or for the purposes of an agency;
 - (h) the nature of the treatment received by the patient or for which the patient was admitted;
 - (i) where the patient has been an in-patient in an independent hospital, the date of the patient's discharge;
 - (j) if the patient has been transferred to a hospital (including a health service hospital), the date of the transfer, the reasons for it and the name of the hospital to which the patient was transferred;
 - (k) if the patient dies whilst in an establishment or during treatment provided for the purposes of an establishment or agency, the date, time and cause of death.
2. A register of all surgical operations performed in an establishment, including—
 - (a) the name of the patient on whom the operation was performed;
 - (b) the nature of the surgical procedure and the date on which it took place;
 - (c) the name of the medical practitioner or dentist by whom the operation was performed;
 - (d) the name of the anaesthetist in attendance;
 - (e) the name and signature of the person responsible for checking that all needles, swabs and equipment used during the operation have been recovered from the patient;

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- (f) details of all implanted medical devices, except where this would entail the disclosure of information contrary to the provisions of section 33A(1)(e), (f) and (g) of the Human Fertilisation and Embryology Act 1990(2) (disclosure of information).
- 3. A register of all mechanical and technical equipment used for the purposes of treatment provided by the establishment or agency, including—
 - (a) the date of purchase of the equipment;
 - (b) the date of installation of the equipment;
 - (c) details of maintenance of the equipment and the dates on which maintenance work was carried out.
- 4. A register of all events which must be notified to the registration authority in accordance with regulations 29 and 30.
- 5. A record of the rostered shifts for each employee and a record of the hours actually worked by each person.
- 6. A record of each person employed in or for the purposes of the establishment or purpose of the agency, which must include in respect of an individual described in regulation 21(1) the following matters—
 - (a) the person's name and date of birth;
 - (b) details of the person's position in the establishment;
 - (c) dates of employment; and
 - (d) in respect of a health care professional, details of relevant professional qualifications and registration with the relevant professional regulatory body.

SCHEDULE 4

Regulation 43(5)

PART 1

Details to be Recorded in Respect of Patients Receiving Obstetric Services

1. The date and time of delivery of each patient, the number of children born to the patient, the sex of each child and whether the birth was a live birth or a stillbirth.
2. The name and qualifications of the person who delivered the patient.
3. The date and time of any miscarriage occurring in the hospital.
4. The date on which any child born to a patient left the hospital.
5. If any child born to a patient died in the hospital, the date and time of death.

PART II

Details to be Recorded in Respect of a Child Born in an Independent Hospital

6. Details of the weight and condition of the child at birth.
7. A daily statement of the child's health.

(2) 1990 c. 37.

8. If any paediatric examination is carried out involving any of the following procedures—
- (a) examination for congenital abnormalities including congenital dislocation of the hip;
 - (b) measurement of the circumference of the head of the child;
 - (c) measurement of the length of the child;
 - (d) screening for phenylketonuria;
 - (e) screening for congenital hypothyroidism;
 - (f) screening for cystic fibrosis;
 - (g) screening for sickle cell disease;
 - (h) screening for medium-chain acyl-CoA dehydrogenase deficiency;
- details of such examination and the result.