SCHEDULE 1

Regulation 5

INFORMATION TO BE INCLUDED IN THE STATEMENT OF PURPOSE

1. The aims and objectives of the establishment.

2. The name and address of the registered provider and of any registered manager.

3. The relevant qualifications and experience of the registered provider and any registered manager.

4. The number, relevant qualifications and experience of the staff working in the establishment.

5. The organisational structure of the establishment.

6. The kinds of treatment and any other services provided for the purposes of the establishment, the range of needs which those services are intended to meet and the facilities which are available for the benefit of patients.

7. The arrangements made for consultation with patients about the operation of the establishment.

8. The arrangements made for contact between any in-patients and their relatives, friends and representatives.

9. The arrangements for dealing with complaints.

10. The arrangements for respecting the privacy and dignity of patients.

SCHEDULE 2

Regulations 9(3), 11(2) and 18(2)

INFORMATION REQUIRED IN RESPECT OF PERSONS SEEKING TO CARRY ON, MANAGE OR WORK AT AN ESTABLISHMENT

1. Positive proof of identity including a recent photograph.

2. Either—

(a) where the certificate is required for a purpose relating to section 115(5)(ea) of the Police Act 1997 (registration under Part II of the Care Standards Act 2000)(**1**), or the position falls within section 115(3) or (4) of that Act(**2**), an enhanced criminal record certificate issued under section 115 of that Act 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 113 of that Act in respect of which less than three years have elapsed since it was issued,

including, where applicable, the matters specified in section 113 (3A) or (3C) or 115 (6A) or (6B) of that Act(**3**).

3. Written references from each of the person's two most recent employers.

(**1**) Section 115(5)(ea) is inserted by the Care Standards Act 2000, section 104, on a date to be appointed. Sections 113 and 115, as amended, have not yet been brought into force.

(**2**) A position is within section 115(3) if it involves regularly caring for, training, supervising or being in sole charge of persons aged under 18. A position is within section 115(4) if it is of a kind specified in regulations and involves regularly caring for, training, supervising or being in sole charge of persons aged 18 or over.

(**3**) Sections 113(3A) and 115(6A) are added to the Police Act 1997 by section 8 of the Protection of Children Act 1999 (c. 14) on a date to be appointed, and amended by section 104 and 116 of and paragraph 25 of Schedule 4 to the Care Standards Act 2000. Sections 113(3C) and 115(6B) are added to the Police Act 1997 by section 90 of the Care Standards Act 2000 on a date to be appointed.

4. 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.

5. Documentary evidence of any relevant qualification.

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

7. 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.

8. Details of any criminal offences—

(a) of which the person has been convicted, including details of any convictions which are spent within the meaning of section 1 of the Rehabilitation of Offenders Act 1974(**4**) and which may be disclosed by virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975(**5**); or

(b) in respect of which the person has been cautioned by a constable and which, at the time the caution was given, the person admitted.

SCHEDULE 3

Regulation 20(1), (3)

PART I

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 refer 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
(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

(**4**) 1974 c. 53.
(**5**) S.I.1975/1023. Relevant amendments have been made by S.I. 1986/1249, 1986/2268 and 2001/1192.

Type of patient	Minimum period of retention
(g) (g) Patient who has received an organ transplant	A period of 11 years beginning on the date of the patient's death or discharge whichever is the earlier
(h) (h) All other cases.	A period of 8 years beginning on the date of the last entry in the record

PART II

RECORDS TO BE MAINTAINED FOR INSPECTION

1. A register of patients, including—

(a) the name, address, telephone number, date of birth and marital 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;

(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, 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;

(f) details of all implanted medical devices, except where this would entail the disclosure of information contrary to the provisions of section 33(5) of the Human Fertilisation and Embryology Act 1990 (restrictions on disclosure of information).

3. A register of each occasion on which a technique or technology to which regulation 41 applies has been used, including—

(a) the name of the patient in connection with whose treatment the technique or technology was used;

(b) the nature of the technique or technology in question and the date on which it was used;

(c) the name of the person using it; and

(d) where the person using the technique or technology is not a medical practitioner, dentist or other competent person, the name of the medical practitioner, dentist or other competent person on whose direction the technique or technology was used.

4. A register of all mechanical and technical equipment used for the purposes of treatment provided by the establishment, 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.

5. A register of all events which must be notified to the Assembly in accordance with regulation 27.

6. A record of the rostered shifts for each employee and a record of the hours actually worked by each person.

7. A record of each person employed in or for the purposes of the establishment, which shall include in respect of an individual described in regulation 18(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 39(5)

PART I

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

1. Details of the weight and condition of the child at birth.

2. A daily statement of the child's health.

3. 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;

details of such examination and the result.