Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Legal Retention and Destruction of Hospital Patient Health Records

This procedural document supersedes: CORP/REC 8 v.5 – Legal Retention and Destruction of Hospital Patient Health Records

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Name of author/reviewer:	Judy Lane – Patient Services Manager
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Agreed by:	Clinical Records Committee
Approved by (Committee/Group):	Policy Approval and Compliance Group
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Target audience:	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date Issued	Brief Summary of Changes	Author
Version 6	23 November 2016	• Updated with the Goddard Inquiry in mind. • Totalcare PAS has changed to CaMIS PAS. • Updated to Medical Records Manager/Patient Services Manager throughout. • Format updated. • Changed appendices from A, B, C to 1, 2, 3.	Judy Lane
Version 5	March 2012	**Major changes throughout – PLEASE READ IN FULL** - Additional guidance on retention periods (Appendix A revised) - Additional guidance on selection of records for destruction (Appendix B revised) - Local retention indicators revised - Roles and Responsibilities identified - Guidance on scanned health records	Dr G Payne Christine Coates Julie Robinson
Version 4	Jan 2009	• Additional Guidance on Destruction Process. • Additional guidance on selection of records for destruction - Appendix B	Christine Coates/ Clinical Records Sub-committee
Version 3	August 2006	• Additional guidance on retention periods • Additional guidance on retention periods for patients diagnosed with Creutzfeldt-Jakob Disease (CJD) • New guidance on electronic records	Christine Coates/ June Hines

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1. INTRODUCTION

Under the terms of the Public Records Act 1958 all NHS records are public records, and all NHS organisations have a duty to make arrangements for the safe keeping and eventual disposal of their records.

The Trust has developed a Code of Practice for the Management of Trust Information Records (**CORP/ICT 14**), where the requirements of the Records Management NHS Code of Practice published by the Department of Health are outlined.

The guidelines contained in the Code of Practice are based upon current legal requirements and professional best practice, and apply to NHS Records of all types regardless of the media on which they are held including electronic or paper based patient health records.

The Code of Practice together with supporting annexes identifies the specific minimum retention periods for the effective management of all types of health records.

A health record for the purpose of this policy is a single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient. This may comprise of text, sound, image and /or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the ongoing care of the patient to whom it refers.

This policy relates specifically to patient health records, and takes as the foundation of its recommendations the Records Management NHS Code of Practice which replaces previous guidance:
HSC 1999/053 - For the Record
HSC 1998/153 - Using Electronic Patient Records in Hospitals; Legal Requirements and Good Practice

2. PURPOSE

The Data Protection Act 1998 states that personal information about a patient processed or held for any purpose should not be retained longer than is necessary for that purpose. Health records held within the Trust will adhere to the minimum retention guidance periods set out in the Records Management NHS Code of Practice, which also takes into account the Limitations Act of 1975 and the Congenital Disabilities (Civil Liability) Act 1976.

3. RETENTION AND DISPOSAL ARRANGEMENTS

For detailed guidance on the retention periods for the full range of health records, refer to Corporate Policy **CORP/ICT 14** - Information Records Management Code of Practice **plus** DoH Records Management Code of Practice Part 1 (RMCoP Part 1) **and** Records Management Code of Practice Part 2 (RMCoP Part 2) attached to that policy.

There are separate and explicit schedules relating to health records, the following types of record are covered:

- Patient health records
- Accident & emergency, birth and all other registers
- Theatre, minor operations and other related registers
- X-ray and imaging reports, output images
- Microfiche/microfilm, audio and video tapes., cassettes, CD-ROM's, etc
- Scanned documents

For ease of reference see **Appendix 1**.
N.B. (N) indicates New guidelines (C) Indicates a Change

4. ROLES AND RESPONSIBILITIES

Operational managers are responsible for familiarising staff with the national or locally agreed retention requirements for patient records within that specialty.

Clinical staff in the operational area that ordinarily uses the records must be familiar with the national and locally agreed retention requirements for patient records within that operational area.

Clinicians must clearly identify where a patients record's must be retained longer than the **standard** period of **8 years** after the date of the patient's last attendance, or 8 years after the date of death for adults, or beyond the recommended **25 years** retention period for paediatric and maternity records.

Where a longer retention period is required, clinicians must indicate this on the front of the folder in the box provided, and date and record the reason as an alert inside the casenote folder.

The Medical Records Manager/Patient Services Manager will on request provide staff undertaking the cull of non-current health records with the relevant deadline dates for retention / destruction decisions and will produce a PAS report to identify patients that have not had an attendance on PAS for 8 years or more. **See Appendix 2.**

Medical Records Department and all clinical admin staff must ensure that a current year label is routinely attached to the outside cover of casenotes to identify the last year of attendance.

e.g. where a patients last attendance was 2012.

2012

This will assist with the annual cull of patient records for pre-destruction preparation. Supplies of current year labels are available from medical records departments.

Where a clinician has indicated that records need to be retained indefinitely, a label must be attached to the casenotes by medical records staff prior to filing.

e.g.

DO NOT DESTROY
RETAIN INDEFINITELY

5. CONFIDENTIALLY REVIEWING AND RECORDING DISPOSAL DECISIONS

The Medical Records Manager/Patient Services Manager must be reassured that only medical records department trained staff will undertake the review of patient health records to determine whether they should be confidentially disposed of.

Reference must be made to:

- Indicators on the front of the casenote folders
- Indicators on the inside cover of the casenote folders
- Indicators on the 'Alert' page inside the casenotes
- Individual retention guidelines particular to specific health record types, see **Appendix 1**
- The basic check list relevant to the current year, see **Appendix 2.**

Scanning Records into Electronic Format
Where for reasons of efficiency or in order to address problems with storage space, before selecting the option of scanning into electronic format records which exist in paper format, first consideration must be given to:

- Whether the format might influence the archival value or evidential value and

- The records must be stored to the required standards (BIP008 - British Standards Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically).

6. RECORDS OF DESTRUCTION AND DISPOSAL

Health records (including copies) not selected for preservation must be destroyed in a secure and confidential manner. This can be undertaken on site or via an approved contractor. The contractor, if used must sign a confidentiality undertaking and produce written certification as proof of destruction i.e. British Standards compliant (BS EN 15713:2009 - Secure destruction of confidential material).

The organisation must ensure that the methods used to dispose of records, showing their reference, description and date of destruction are maintained and preserved so that the organisation is aware that the records have been destroyed and are no longer available.

If a record due for destruction is known to be the subject of a request for information, or potential legal action, destruction must be delayed until disclosure has taken place or legal process has been completed.

If after the required checks, it is determined that case notes are still eligible for destruction:

- Destroyed health records must be tracked on the Clinical Record tracking module as destroyed e.g. Tracking Code DEST 2012 = Destroyed 2012. This must include records destroyed by an agency contracted by the Trust.

- Treatment numbers must not be removed from PAS when casenotes have been destroyed.

- The previously destroyed folders must remain tracked to the destroyed location code indicating that the casenotes were destroyed.

7. PERMANENT RETENTION

Records may not ordinarily be retained for more that 30 years unless the retention schedules in **CORP/ICT 14** specify, but the Public Records Act provides for records still in current use to be legally retained.

If the organisation identifies patient health records to be preserved as archives, consult with the National Archives, refer to **CORP/ICT 14.**

8. TRAINING AND EDUCATION

Full training is given to all staff within the Health Records Department to ensure compliance with the National Guidelines on Health Records Retention Summary – see **Appendix 1.** This is to be used in conjunction with **Appendix 2** – Procedural Check List.

9. MONITORING AND COMPLIANCE

Compliance with this policy will be monitored by the Medical Records Manager/Patient Services Manager by use of the PAS system reports, and casenote structure audits.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
The correct retention and destruction of patient casenotes.	Patient Services Manager Assistant Medical Records Managers	Yearly	By use of the PAS system reports (Clinical Record tracking module). Any deviations will be reported on DATIX.

10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (see Appendix 3).

11. OTHER ASSOCIATED TRUST PROCEDUREAL DOCUMENTS

CORP/ICT 14 - Information Records Management Code of Practice

12. REFERENCES

Public Records Act 1958
Limitations Act 1975
Congenital disabilities (Civil Liability Act 1976)
Data Protection Act 1998
Department of Health Records Management Code of Practice
BIP008 - British Standards Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically.
BS EN 15713:2009 - Secure Destruction of Confidential Material.

APPENDIX 1 – HEALTH RECORDS RETENTION SUMMARY

	Local or National Guidance	RECORD TYPE	MINIMUM RETENTION PERIOD *Retention periods should be calculated from the end of the calendar year following the last entry (clinicians must indicate where records should be retained longer/or the advice of the relevant clinician/s should be sought).
1	Nat (N)	Children and young people (all types of records relating to children and young people)	Retain until patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, **or** 8 years after death. Clinicians must indicate if illness or death could have potential relevance to adult conditions or have genetic implications.
2	Nat	Child & Family Guidance	Retain for the period of time appropriate to the patient – e.g., children's records as in 1 above; mentally disordered persons (within the meaning of the Mental Health Act 1983) as in 12 below **or** 8 years after the patient's death if they died while in the care of the organisation.
3	Nat (N)	Child Health records	See 1 above.
	Nat (C)	Patients involved in Clinical Trials	See 22 below. There should be a flag in the health records pertaining to the research/trial, the responsible clinician should note participation in a clinical trial on the Alert page and indicate if longer term retention is required.
4	Nat (C)	Counselling / Clinical Psychology / Psychotherapy Records	Retain **20** years or 8 years after death if the patient died in the care of the organisation.
5	Nat	Creutzfeldt-Jakob Disease	Retain **30** years from date of diagnosis, including deceased patients.
6	Nat	Dental, Ophthalmic and Auditory screening records	Retain **11** years for adults; for children, 11 years or up to their 25th birthday, whichever is the longer.
7	Nat (N)	DNA (health records of patients who did not attend for appointments as outpatients).	Where there is a letter informing the referrer – Retain 2 years Where there is no letter informing the referrer – Retain for period appropriate to patient or specialty.
8	Nat (N)	Endoscopy Records	Retain **20** years **or** 8 years after the patient's death if the patient died while in the care of the organisation.
9	Nat (C)	Family Planning/ Contraception/ GUM (includes sexual health) records.	Adults - Retain **10** years after the last entry. Under age 18 - Retain until 25th birthday **or** 10 years whichever is longer. Records of deceased persons - Retain 8 years after death.
10	Nat	Immunisation and Vaccination records	Children and young people see 1 above. Adults – Retain **10** years after conclusion of treatment.

11	Nat (**C**)	Joint replacement records	Retain **10** years (only the notes with specific information about the original prosthesis)
12	Nat	Maternity records (all obstetric and midwifery records including those episodes of care that end in stillbirth or where the child later dies).	Retain for 25 years after the birth of the last child.
13	Nat (**N**)	Mental Health Records – Child & Adolescent (includes psychology records not listed elsewhere.	Retain **20** years from date of last contact, or until patient's 25th / 26th birthday, whichever is the longer period.
14	Nat	Mentally disordered patients (within the meaning of any Mental Health Act)	Retain **20** years after the date of last contact between the patient and any healthcare professional employed by the provider, **or** 8 years after the death of the patient if sooner.
15	Nat (**N**)	Occupationally Related Diseases	Retain **10** years after date of last entry in record.
16	Nat	Oncology	Retain **30** years.
18	Nat	Photographic Records	Retain **30** years where images present the primary source of information for the diagnostic process.
20	Nat	Scanned Records relating to patient care	Retain for the period of time appropriate to the patient/specialty NB Provided that the scanning process and procedures are compliant with BSI's BIP:008. Once the casenotes have been scanned the paper records can be destroyed under confidential conditions.
21	Nat (**C**)	X-Ray films (including other image formats for all imaging modalities/diagnostics) Breast Screening X-rays Mammograms and Reports	Retain for the period of time appropriate to the patient/specialty after conclusion of treatment. Retain **9** years after final attendance Screen detected cancers, Interesting cancers – Retain **indefinitely** Research cases – Retain **15** years after final attendance Age trial – cases – Retain **9** years Deaths – Retain **9** years Where product liability is involved - Retain **11** years
22	Nat	**All other records** (including photographs)	**Retain 8 years after the date of the patient's last attendance, or 8 years after date of death.**

Other important periods for retention for paper- based records:

Record	Minimum Retention Period
Suicide notes of patients having committed suicide	10 years
Referral letters for patients treated by the organisation to which they were referred. Referral letters not accepted	File in the service users health record - Retain appropriate to the care / treatment provided. Where there is correspondence detailing the reason for non-acceptance - Retain for 2 years after decision not to accept. Where there is no correspondence detailing reason for non-acceptance - Retain for period appropriate to the patient / specialty.
Post Mortem Registers	30 years
Operation Registers	8 years
A&E Registers	8 years
Admissions and Discharge Books	8 years
Duplicate patient record notification forms	2 years

APPENDIX 2 – PROCEDUREAL CHECK LIST

1. **Check** in the casenotes and all attendances recorded on PAS, look for attendances on **all Trust sites.**

2. **Retain** all casenotes where the patient has:
   - **Attendances** recorded on PAS from the year ……. to the present day

   or
   - **Date of Birth** from the year ……. onwards.

3. **Confidentially Destroy** if the casenote and PAS indicate that since the Applicable years indicated above the patient has not attended or has only attended:
   - A&E
   - X-Ray
   - Physiotherapy
   - Orthotics
   - Orthopaedic Screening

4. **Record the year** that the patient last attended on the outside cover of the Folder if it is not recorded or is inaccurate.

5. **Before confidentially disposing** of casenotes, where the patient attended before the above dates **first check:**
   - The **retention grid** on the front of the casenote folder and
   - The **alert notices** inside the casenotes for any special retention instructions and
   - The **casenotes** and
   - **Appendix 2 of CORP/REC 8** for any of the diagnosis / history indicated where the following retention periods apply:

     5 years retain from year …… onwards
     9 years " …… "
     10 years " …… "
     11years " …… "
     15 years " …… "
     20 years " …… "
     30 years " …… "

6. **Track destroyed casenotes** (e.g. to code DEST2012)

Do not remove the treatment number from PAS when casenotes have been destroyed.

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Legal Retention and Destruction of Hospital Patient Health Records	Corporate - Performance	Judy Lane	Existing	September 2016

1) Who is responsible for this policy? Name of Care Group/Directorate: Performance

2) Describe the purpose of the service / function / policy / project/ strategy? Casenotes are destroyed in line with National and local guidelines

3) Are there any associated objectives? National and local guidelines and standards

4) What factors contribute or detract from achieving intended outcomes? Non-compliance

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2019

Checked by: Judy Lane **Date: September 2016**