HEALTH BOARD MINIMUM RETENTION & DESTRUCTION POLICY

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PLEASE SEE POLICY HB13 HEALTH RECORDS POLICY

Policy Owner: **Director of Digital Services**

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MINIMUM RETENTION & DESTRUCTION POLICY FOR PATIENT HEALTH RECORDS ONLY

1. AIM OF POLICY

The aim of this policy is to ensure that the retention period for health records is maintained in accordance with Statute law as outlined in this document and that the destruction of health records is undertaken by approved contractors/internal procedures whereby ensuring that patient confidentiality is maintained at all times

It is the responsibility of all areas to enforce the Health Board Retention and Destruction Policy in all areas that hold patient records.

The destruction of all types of patients records both paper and electronic is on hold due to the embargo as a result of the Infected Blood Inquiry. There is no indication at the time of updating the Policy when the Embargo will be lifted.

2. BACKGROUND AND CONTEXT

All NHS records are public records under the terms of the Public Records Act, 1958 S.3 (1) -(2). NHS Trusts have a statutory duty to make arrangements for the safekeeping and eventual disposal of all such records.

The Records Management Code of Practice 2016, sets out the guidelines to be followed in the management of all types of NHS records including their creation, use and final disposal. This document replaces all previous circulars in relation to the retention, preservation and destruction of health records.

A health record is "*one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual*".

Patient health records can be electronic, paper based or a mixture of both, and includes private patients seen on NHS premises. Also included are patient records that have been archived onto microfilm (*i.e.* fiche or film), by digitally scanning, or any other media.

NOTE: For information on retention and destruction guidelines for all other types of records held within the Health Board, please refer to the Records Management Strategy.

3. RESPONSIBILITY

- Chief Executives and Senior Managers of all NHS bodies are personally accountable for records management within their organisations and have a duty to make arrangements for the safe-guarding of these records.

- This duty arises from statute and relates from safe-keeping to the eventual disposal/destruction.

- However, all Line Managers, whether Administrative or Clinical, must be adequately trained and able to apply these guidelines.

- In practice, all individuals as NHS staff are responsible for the records they create or use. As employees of the NHS, any records created by staff are public records.

4. LEGAL CONTEXT

This policy must be applied in conjunction with the laws relating to confidentiality, data protection, the patient's rights of access to his/her health records and the staff's duty of care to patients to make proper records. Managers in all Delivery Units must ensure that staff are also aware of these rules.

5. PENALTIES

All staff should be aware of the vital role that records play in delivering healthcare. Audit commission reports have shown that there is considerable room for improvement as many NHS Organisations have failed to look after their records properly. This Policy is designed to help assist in this improvement process.

6. RETENTION OF HEALTH RECORDS

Access to the health record is essential to the patient care process. Patient health records must therefore be retained securely for the whole period that the patient is receiving active treatment and care and must be retrieved easily from storage whenever they are required by a clinician.

Consideration also needs to be given to the Department of health guidance on Records Management 2016 NHS code of Practice, which has already been implemented in England which details Retention Periods for all types of Health Records

Pre 1948 records	These should by now have been transferred for permanent preservation or destroyed. Any pre-1948 records which still exist should be considered for permanent preservation, undergoing an appraisal procedure as described above.
Obstetric records:	25 years after conclusion of pregnancy and the puerperium. Where a separate record has been established for the baby, this record must also be retained for 25 years, whether the baby is stillborn or a neonatal death.
Children	Until the patient's 25th birthday or 26th birthday if the young person was 17 at conclusion of treatment; or 8 years after patient's death if the death occurred before 18th birthday.
Oncology records:	8 years after conclusion of treatment, especially when surgery only is involved. Consideration may wish to be given to BFCO (96)3 issued by the Royal College of Radiologists which recommends permanent retention on a computer database when patients have been given chemotherapy and radiotherapy.
Clinical trials:	15 years after conclusion of treatment (this should be documented on the inside front cover of the case record)
Mentally disordered persons:	20 years after no further treatment considered necessary. Or 8 years after the patient's death if patient died while still receiving treatment.
Deceased patients:	Such records need only be retained for a minimum period of 8 years after the death of a patient except for stillbirths and neonatal deaths where records must be kept for 25 years.

Health Records staff will be responsible for monitoring the minimum retention periods to be applied in each individual case following conclusion of treatment once the embargo on the destruction of records is lifted. Operational procedures adopted within Health Records Libraries will facilitate this process.

7. COMPUTERISED RECORDS

The recommended minimum retention periods apply to both paper and computerised records. System Managers and Data Owners of key Information Systems will take account of the minimum data retention periods and requirements to dispose of data in line with this Policy in each individual System Security Policy and System Operating Procedures.

8. PRESERVATION

If and when the embargo on the destruction of records is lifted, and there is a need to retain a patient's health record beyond the recommended minimum retention period, the case must be presented to the Information Governance Group (IGG) for their approval to retain the record, or not, this requirement must be noted on the inside front cover of the case note.

It may be deemed appropriate to select some health records for permanent preservation. Selection should be performed in consultation with health professionals, and archivists from an appropriate place of deposit.

9. Destruction

If the health record[2] remains inactive beyond the minimum retention periods outlined above, the record will be destroyed in line with this policy if and when the embargo on the destruction of records is lifted .

Prior to the destruction of the health record all relevant Swansea Bay University Health Board Systems must be checked for most recent patient activity.

Destruction of health records must ensure that their confidentiality is fully maintained. Normally destruction should be by incineration or shredding. Where this service is provided by a contractor, it is the responsibility of the Health Board to satisfy itself that the methods used throughout all stages including transport to the destruction site provide satisfactory safeguards against accidental loss or disclosure.

[2] A patient health record can be either electronic or paper based. All records containing patient information are included, whether they are held within the main hospital case note, or not [e.g. physiotherapy, community, A&E records]. Also included are the records of private patients seen on NHS premises.