HEALTH RECORDS SERVICES

RETENTION AND DESTRUCTION OF PERSONAL HEALTH RECORDS POLICY

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Health Records Services

Retention and Destruction of Patient Records Policy

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NHS Board Policy for Transportation of Paper Records Containing Business or Person Identifiable Information.	

1. Policy Aim

This policy aims to establish a framework through which NHS [insert board] is able to meet its statutory obligations for the safekeeping and eventual disposal of personal health records.

2. Introduction and Scope

All NHS organisations are obliged under Data Protection 1998 and Freedom of Information (Scotland) Act 2002 legislation to make arrangements for the safe keeping and eventual disposal of all types of their records. The records they create are subject to the Public Records (Scotland) Act 2011.

NHS Boards are required to comply with the Information Governance standards set out in the Clinical Governance and Risk Assessment standards[1][2]. These include standards applicable to administrative and patient records[3].

The policy refers to the following personal health records (regardless of the media on which they are held, e.g. paper, electronic, Microform (microfiche and microfilm), images and sound:

- All specialties
- Accident Emergency, birth and all other registers;
- Theatre, minor operations and other related registers;
- NHS patients treated on behalf of the NHS in the private sector
- Private patients seen on NHS premises;

and takes as the foundation of its recommendations the following:

- Scottish Government: Records Management NHS Code of Practice
- The Data Protection Act 1998

The Data Protection Act 1998 states that personal information about a patient processed or held for any purpose should not be kept longer than is necessary for that purpose. Retention and destruction of health records held within NHS [insert board] will adhere to the following minimum retention periods.

The requirements of this policy apply to all patient records regardless of the media on which the information is held e.g. paper, electronic.– its does not apply to non-clinical records- please refer to the [insert policy] for further information.

The Policy will be reviewed at least annually and also updated when required taking into account any new legislation and the operational requirements of NHS [insert board].

[1] Clinical Governance Risk Management Standards, NHS QIS Oct 2005
[2] NHSScotland Information Governance Standards
[3] NHSScotland Information Governance Standards

3. Retention Periods

The records retention schedule (Appendix 1) has been endorsed by the NHS [insert board xxx committee] and specifies the:

- The time period from the last date of attendance to the transfer to secondary storage
- The minimum retention periods for various health records created within the NHS or by predecessor bodies due to their ongoing administrative value or a statutory requirement. The Schedule takes into account Principle 5 of the Data Protection Act 1998 and Annex D of the Records Management: Code of Practice [4]

These retention periods will be calculated from the end of the calendar year following the last entry in the record.

Minimum retention periods for other record types are not included in this schedule. Advice can be sought from the Head of Health Records Services.

4. Records Inventory

A records inventory will be established and maintained by the Health Records Service. An entry will be created for each personal health records system which exists in NHS [insert board] both current and archival. The requirements of the records retention/disposal schedule will be applied consistently to each records system according to the classification of record type e.g. general, paediatric, mental health etc.

5. Identification of Records Suitable for Transfer to Secondary Storage Facility

The main methods used to identify when a record becomes non-current are dependant on the functionality of the Scottish Foundation Patient Management System and the various legacy Patient Administration Systems as well as the physical filing systems. The approved time periods for each records system can be found in the records retention/disposal schedule at Appendix 1

6. Appraisal of Records for permanent preservation

Appraisal refers to the process of determining whether records are worthy of permanent archival preservation. Whenever a review is undertaken of a records system with a view to destruction of records consideration will be given to whether records may have long-term historical or research value and advice sought from the NHS [insert board] archivist. [insert contact details].

No surviving personal health record dated 1948 or earlier will be destroyed.

Where a decision is taken to destroy records from a particular personal health records system a small sample of records will be selected for transfer to the archive so that these are available for historical and research purposes.

[4] Records Management Code of Practice: (V2) Scottish Government, August 2010

7. Identification of Records Suitable for Destruction

Personal health records created by [insert NHS Board] and predecessor bodies are retained in accordance with the minimum retention periods set out in Annex D of the SG Records Management Code of Practice[5]. A summary of the minimum retention periods which apply to the various record types can be found in the records retention/disposal schedule at Appendix 1 of this document. Records which must not be destroyed include:

- Records with special markings or stamped "Do not Destroy this Record"
- Records which mention that the patient has a genetic disorder

In addition a process is in place to identify records concerning patients who have raised a complaint which remains unresolved or whenever there is ongoing litigation. Whenever original or copy records have been produced for the Procurator Fiscal or under Court Order and the case has not been confirmed as closed, the record will be retained.

Records for patients (alive or deceased) marked or labelled clinical trial will be retained for 15 years after date of last attendance

Whenever the content of a personal health record has been examined and a clinical decision taken to retain the record for longer than the minimum retention period, the relevant Master Patient Index entry will be updated 'To be retained'.

In addition to examining the contents of a paper record, electronic systems which hold the patient's visit history will be crosschecked prior to the final decision to destroy the record.

8. Destruction of Personal Health Records and Litigation

The minimum retention periods given in this policy take account of the need for evidence in legal actions. Once the appropriate minimum retention period has expired the [insert NHS Board] will not retain Personal Health Records indefinitely for the purpose of future litigation.

Where Personal Health Records are identified as having been/are being used in cases of litigation, reference must be made to the [insert board contact details e.g. Legal Services Department] before destruction.

In the event of a Clinician involved in litigation claiming that the prior disposal of relevant Personal Health Records has prejudiced the outcome, this fact will be considered along with all other influencing factors.

9. Transportation of Records

Personal Health Records will be transported in accordance with the NHS [insert board] Policy for Transportation of Paper Records Containing Business or Person Identifiable Information.

[5] Records Management Code of Practice: (V2) Scottish Government, August 2010

10. Destruction of Records

Whenever the content of a record has been examined and a clinical decision taken to destroy the record the Master Patient Index entry will be updated with 'Destroyed' along with the destruction date so that this is immediately known should the patient/client represent to the service or make an enquiry for access to their health records.

The destruction of patient records will be undertaken in a manner that ensures confidentiality is maintained.

All records for destruction will be incinerated, pulped or cross shredded. If this is undertaken by an outside agency, the contractor must accept responsibility for insuring against accidental loss or disclosure. Contracts with such agencies should always be agreed via [insert board contact details e.g. legal services or procurement department etc].

Contractors used to undertake the destruction process will be certified to do this type of work, and a certificate of compliance will be issued and held indefinitely within the relevant Health Records Department each time a Contractor is engaged.

All staff involved with the retention and destruction of patient records should ensure that they are familiar with the Records Management NHS Code of Practice and the local Health Records Departmental Procedural Guidelines, which are maintained within the Health Records Service.

11. Monitoring, Compliance & Effectiveness

The destruction programme of main health records will take place at the beginning of each calendar year. This will be managed by the Health Records Department in conjunction with Information Department and approved by the NHS [insert board xx Committee].

In order to meet information governance requirements and provide assurance to clinicians, patients/clients, processes will be established to quality assure the competence of staff undertaking procedures to establish records suitable for destruction. A 10% sample of records will be double checked by a second experienced staff member using the agreed protocol for the records system

All other clinical record types created by [insert board] will be managed in accordance with departmental protocol and in compliance with this policy and national guidance.

Note: Should you wish to discuss other record types not included in this policy, please contact the Head of Health Records Services or Information Governance Manager who will be able to assist you with your enquiry.

Sample NHS [insert board] - Retention/Disposal Schedule

This records retention or disposal schedule sets out which records need to be retained, for how long and what their ultimate fate is, i.e. transfer to archival store, destruction or permanent preservation. Whenever a review is undertaken of a records system with a view to destruction of records consideration will be given to whether records may have long-term historical or research value and advice sought from the NHS [insert board] archivist. [insert contact details]

No surviving personal health record dated 1948 or earlier will be destroyed.

Where a decision is taken to destroy records from a particular personal health records system a small sample of records will be selected for transfer to the archive so that these are available for historical and research purposes.

Record Type	***Minimum Retention Period (SG Records Management COP Version 2.0)***	***Site***	***Period from date of last attendance to transfer to secondary store***	***Period from date of last attendance to destruction***	***Final action***
Adult	6 years after date of last entry or 3 years after death if earlier	***All sites***	3 years	6 years after date of last entry or 3 years after death if earlier	Destroy
Children and young people (including children's and young persons mental health records and neo-natal records)	Retain until the patient's 25 birthday or 26th if young person was 17 at conclusion of treatment or 3 years after death If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period	***All sites***	2 years	Retain until the patient's 25 birthday or 26th if young person was 17 at conclusion of treatment or 3 years after death	Destroy

Record Type	***Minimum Retention Period (SG Records Management COP Version 2.0)***	***Site***	***Period from date of last attendance to transfer to secondary store***	***Period from date of last attendance to destruction***	***Record Type***
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child	***All sites***	Following Delivery	25 years after the birth of the last child	Destroy

Record Type	***Minimum Retention Period (SG Records Management COP Version 2.0)***	***Site***	***Period from date of last attendance to transfer to secondary store***	***Period from date of last attendance to destruction***	
Mentally Disordered Persons (within the meaning of the Mental Health (Scotland Act 2003)	20 years after date of last contact between the client/service user and any health care professional employed by the mental health provider, or 3 years after death of the patient/client/service user if sooner and the patient died while in the care of the organisation. When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take in to account any genetic implications of the patient's illness. If it is decided they to retain the records, they should be subject to regular review	***All Sites***	3 years	20 years after date of last contact between the client/service user and any health care professional employed by the mental health provider, or 3 years after death of the patient/client/service user if sooner and the patient died while in the care of the organisation	Destroy
Oncology (including radiotherapy)	30 years. Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes	***All Sites***	6 years	30 years	Destroy
Clinical Psychology	30 years	***All Sites***	3 years	30 years	Destroy

Record Type	***Minimum Retention Period (SG Records Management COP Version 2.0)***	***Site***	***Period from date of last attendance to transfer to secondary store***	***Period from date of last attendance to destruction***	***Record Type***
Dental, ophthalmic & auditory screening records	Adults – 11 years Children – 11 years, or up to 25th birthday, whichever is the longer	***All Sites***	3 years	Adults – 11 years Children – 11 years, or up to 25th birthday, whichever is the longer	Destroy
Genetic Records	30 years from date of last attendance	***All Sites***	3 years	30 years from date of last attendance	Destroy

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