Deputy Chief Executive's Office &
Directorate of Operations
Clinical Support Services
Health Records Library

RETENTION, APPRAISAL AND DISPOSAL OF CLINICAL PAPER HEALTH RECORDS POLICY AND PROCEDURE

Reference:	DCP020
Version:	2.0
This version issued:	05/04/18
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	06/02/18 / 21/02/18
Approving body:	Health Records Committee / Clinical Support Services Governance
Date for review:	August, 2020
Owner:	Julie Taylor, Head of Clinical Effectiveness
Document type:	Policy
Number of pages:	17 (including front sheet)
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Contents

1.0 Purpose

1.1 The aim of this Policy and Procedure is to establish a framework through which the Trust is able to meet its statutory obligations under the Public Records Act 1958 and in accordance with Controls Assurance Standards DOH 2016 for the retention, appraisal and eventual disposal of patients' clinical, physical Health Records.

1.2 The Trust has a statutory duty to implement a Policy and Procedure to meet statutory obligations and to take into account the Trust's Risk Management Policy and Strategy.

1.3 In addition the Trust must also comply with the statutory restrictions of the Data Protection Act 1998.

2.0 Area

This policy only applies to the Trust's patients' clinical paper Health Records – it does not apply to patients' clinical electronic Health Records or non-clinical records – please refer to the Trust's Directorate of Strategy, Planning & Performance Information Systems and the Trust's Non-Clinical Records Strategy for further information.

3.0 Responsibilities

3.1 It is the responsibility of the Specialty Administration Teams (SATs) to inform the Health Records Committee (HRC) of diagnoses or surgical procedures that require preservation longer than the minimum retention period.

3.2 It is the responsibility of clinical staff to inform the Health Records Management Team (HRMT) of Health Records which require retaining beyond their minimum retention period.

3.3 It is the responsibility of all Clinicians and custodians of the Trust's clinical, paper Health Records to adhere to the requirements of this policy.

3.4 It is the responsibility of the Systems Implementation Team to ensure the script on the destruction query exclusion table is updated as required.

3.5 It is the responsibility of the HRMT to inform the HRC of any imminent destruction of patients' clinical physical Health Records and obtain approval which is reflected in the minutes.

3.6 It is the responsibility of the HRMT to run the destruction query report timely and before any Health Records are 'pulled', check a random sample of Patient Master Index (PMI) numbers against the Patient Administration System (PAS) demographics i.e. dates of birth and last seen episode dates to ensure meet the destruction criteria (Appendix B).

3.7 It is the responsibility of the HRMT once the pulling of the Health Records is in progress that random samples of up to at least 100 Health Records are checked against an exclusion to destruction checklist (Appendix A) before the Health Records are sent off site for disposal.

3.8 If anomalies are identified in either 3.4 or 3.5, it is the HRMT's responsibility to inform the Systems Development Team – this team will check the destruction query and rectify the query script rules as necessary.

3.9 It is the responsibility of the HRMT to ensure a log is kept of destroyed Health Records and is retained on 'H' drive. HRMT will also ensure Destruction Certificates are obtained and retained for minimum 20 years.

4.0 Retention Schedule – Minimum Retention Periods

4.1 Clinical patient Health Records are required to be retained for minimum periods to take account of The 1980 Limitation Act for England and Wales and The Congenital Disabilities (Civil Liability) Act 1976.

4.2 The minimum retention periods for Clinical Patient paper Health Records (includes electronic) held by the Trust is determined by the Records Management Code of Practice for Health and Social Care 2016. A snapshot from the Records Management Code of Practice of retention periods pertaining to Main/Maternity and frequently used Clinical Records are set out in the following table.

4.3 **For the full Retention Schedule, please use the following link:**

Annex D1: Health Records Retention Schedule

4.4 Snapshot of Retention Schedule – pertaining to Main/Maternity Health Records and other frequently used clinical records

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

4.6 Minimum Retention Periods:

Main Health Records/Maternity Records and other frequently used clinical records

Record Type	Minimum Retention Period
A & E Records (Emergency Care Centre) Stored separately from the Main Health Record	Retain for the period of time appropriate to the patient/specialty Main Record e.g. Children's A&E records should be retained as per the retention periods for the Main Records of children and young people
Allied Health Professional Records If stored separately from the Main Health Record	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people
Ambulance Records	10 years 10 years post date of death

Record Type	Minimum Retention Period
Asylum Seekers and Refugees (NHS personal health record – patient held record)	Special NHS record – patient held – no requirement to NHS for retention
Coronary Related diagnosis/procedures **CABG (Coronary Artery Bypass Grafting)** **Cardiac Valve Replacement** **Cardio-Thoracic Surgery** **Pacemaker Fittings**	**All procedures:** **Lifetime of patient** **8 years post date of death**
Clinical Trials **Health Records** of participants that are the source data in respect of investigational medicinal products	**Trials to be included in regulatory submissions:** At least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period if required by the applicable regulatory requirement(s) or by agreement with the Sponsor. It is the responsibility of the Sponsor to inform the institution as to when these documents no longer need to be retained **Trials which are not to be used in regulatory submissions** At least 5 years after the completion of the trial. These documents should be retained for a longer period if required by the applicable regulatory requirements(s), the Sponsor or the funder of the Trial. In either case, if the period appropriate to the specialty is greater, this is the minimum retention period
Creutzfeldt–Jakob Disease (CJD) Clinical/Main Health Records containing diagnosis of CJD	30 years from the date of diagnosis 8 years post date of death however to be reviewed to ascertain if any need to extend retention period (e.g. any serious incidents)

Record Type	Minimum Retention Period
Death Certificate Counterfoils	2 years
Deceased Patient Main Health Records	8 years post date of death unless diagnosis/record type indicates otherwise
Donor Records (Blood & Tissue)	30 years post transplantation 30 years post date of death(including deceased patients)
Joint Replacements: **Main Health Records of patients who have undergone:** **Elbow Replacement** **Hip Replacement** **Knee Replacement** **Shoulder Replacement**	Lifetime of patient 8 years post date of death
Main Health Records **Adult**	 8 years after conclusion of treatment 8 years post date of death
Main Health Records **Children / Young People** **Pre and Post Adoption Health Records**	 Until 25th birthday or 26th if young person was 17 at conclusion of treatment Same for live and deceased Retention period being queried at present – in meantime, mark as Life Preservation in the qualifier field on PAS

Record Type	Minimum Retention Period
Maternity Health Records **(all Obstetric and Midwifery Records including those of episodes of maternity care that end in still birth or where the infant later dies and maternal deaths)** Includes: Booking data and pregnancy records Antenatal visits and examinations Antenatal inpatient records Clinical test results Blood test results All intrapartum records including CTG's Drug prescriptions and administrative records Postnatal records (Hospital and Community) of both mother and baby	25 years after the birth of the last child
Medical Illustrations **Stored within Main Health Record** **Stored separately from the Main Health Record**	Retain for the period of time appropriate to the patient/specialty/diagnosis e.g. retain as per the retention period for children/young people Retain same as above
Mental Health Records (Patient has been cared for under The Mental Health Act 1983 – includes Psychology records)	20 years after no further treatment considered necessary 8 years post death if the patient died while still receiving treatment

Record Type	Minimum Retention Period
Oncology including Radiotherapy & Chemotherapy Clinical Health Records containing diagnosis/treatment of above	30 years 30 years post date of death **N.B.** records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes
X-Ray Films	7 years after the image was taken 7 years post date of death

4.7 **Community Clinical Health Records – refer to Health Records Management Policy & Strategy for the Retention Periods – Link:**

Health Records Management Policy and Strategy (DCP277)

4.8 In addition to Personal Health Records, the Trust holds patient based information on a number of departmental registers and within various activity reports.

4.9 The minimum retention period for such registers and activity reports held by the Trust is given below as per the Records Management Code of Practice for Health & Social Care 2016:

Registers - Minimum Retention Periods

Register Type	Minimum Retention Period
Accident and Emergency (paper format)	8 years after the year to which they relate – (however likely to have archival value)
Admission Books	8 years after the year to which they relate – (however likely to have archival value)
Child Protection Register (records relating to)	Retain until the patient's 26th Birthday
Discharge Books (where they exist in paper format)	8 years after the year to which they relate – (however likely to have archival value)
Mortuary registers (paper format)	10 years (however likely to have archival value)
Operating Theatre	8 years after the year to which they relate – (however likely to have archival value)
Birth Register	Permanent preservation
Blood bank register	30 years to allow full traceability of all blood products used

Register Type	Minimum Retention Period
Post Mortem register	30 years (however likely to have archival value)
Pharmacy	2 Years
Patient Activity Data	3 Years
Records of Health Records Destruction	Permanent Preservation
X-Ray Registers	30 years (however likely to have archival value)

4.10 **Blood / Blood Products -** On July 2017 the Government announced an independent inquiry into contaminated blood – the events that led to people being infected with HIV or hepatitis C through NHS-supplied blood or blood products in the 1970's and 1980's. Many documents relating to blood safety, covering the period of 1970-1995 have been published and are available in the National Archives.

4.10.1 NHS improvement needs to ensure that it does not destroy any relevant documentation relating to the events that led to people being infected with HIV and/or Hepatitis C through NHS-supplied blood or blood products. Documents and records in relation to blood work may be held by the Medical and the Nursing Directorates in particular.

4.10.2 Staff should retain all relevant documents and other records for the duration of the Inquiry. For further details and updates on the Inquiry:

https://www.gov.uk/government/news/pm-statement-on-contaminated-blood-inquiry-11-july-2017

4.11 **'Ad Hoc' Scenarios whereby Health Records should be retained within the destruction report query rules:**

- **Permanent Preservation:** Personal Health Records of individual patients will not normally be retained permanently under the Public Records Act 1958 however, in the rare event of a Personal Health Record deemed worthy of permanent preservation, Consultant Medical Staff/Clinical Practitioner should annotate the record appropriately on the Health Record Alert Card filed at the front of the Health Records folder and giving the reason/date/name/designation. The HRMT should be contacted to ensure the electronic PAS record is annotated in the qualifier field – this ensures exclusion from any future destruction reports. The HRMT will also ensure a permanent preservation (PP) sticker is adhered to the front of the front cover of the records. The Health Record will be retained by the Trust or if considered appropriate, moved to a place of deposit appointed by the Lord Chancellor for that purpose (i.e. Public Records Office). PAS is annotated in the qualifier field: *PERMP*. These records will not be destroyed until the *PERMP* is removed from PAS. *PERMP* field is validated on request by the HRMT contacting the Information Department to run the appropriate report

- **Life Preservation:** It may be required to retain a record beyond the minimum retention period e.g. patient participating in a clinical trial/a patient who has had a diagnosis/procedure that may require review beyond 8 years with no activity in between. Consultant Medical Staff/Clinical Practitioner should annotate the record appropriately and contact the HRMT to ensure PAS is annotated and sticker (LP) adhered to the front cover of the Health Record folder. PAS is annotated in the qualifier field: *LIFEP*. These records will not be destroyed until 8 years post date of death

- **Legal Preservation:** When a patient has a litigation case in progress, the Medico-Legal or Litigation Department will advise that the Health Records need to be retained for the duration of the legal case. The HRMT ensures PAS is annotated in the qualifier field as *PERMPL* and an orange Medico-Legal (*PERMP-L*) is adhered to the front of the front cover of the records: The Health Records are retained until the Litigation Department advises the Legal Preservation notation on PAS and on the front of the records can be removed

- Once the appropriate minimum retention period has expired the Trust will not retain Personal Health Records indefinitely for the purpose of future litigation

- 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 by the Litigation Department along with all other influencing factors

- The cost of indefinite retention of records would greatly exceed the liabilities likely to be incurred in the event of any defence to an action for damages being handicapped by the absence of records

4.12 Private Patients

4.12.1 Personal Health Records of Private Patients admitted onto NHS wards under Section 58 of the National Health Services Act 1977, or section 5 of the National Health Service Act 1946, whilst technically exempt from the provisions of the Public Records Act, do contain information which meets the criteria for retention and should be treated in the same manner as any other Personal Health Record. Clinicians should keep their own personal records of private patients separate from NLaG Health Records however the NLaG Health Record may contain information in respect of the private patient attendance and therefore the information contained in the NLaG Health Record should be retained in line with the criteria of minimum retention periods. The record of attendance will need to be recorded on PAS in order to ensure retention.

4.12.2 Currently, private patient inpatient attendances are recorded on PAS however work is in progress to record on site/off site private patient clinic attendances therefore if a Clinician wishes particular records to be kept for minimum retention periods or Life/Permanent Preservation due to the private patient clinic attendance, the HRMT will need to be contacted:

- DPoW: 303678 / 303875 / 303930

- SGH / Goole: 303524 / 302106 / 302154

5.0 Appraisal

5.1 There will be one of three outcomes from appraisal:

- Dispose & destroy
- To retain for a longer period
- To transfer to a place of deposit appointed under the Public Records Act 1958

5.2 Appraisal is the process of deciding what to do with records when their business use has ceased. Records cannot be automatically destroyed and imminent disposal and destruction of records will be communicated via Medial Advisory Committee (MAC) and Hospital Consultants Committee (HCC) enabling clinicians to contact the HRMT and advise if further retention period is required before disposal and destruction takes place. Audit, Risk & Governance (ARG) Committee will also need to be informed and this communication should take place at least 8 weeks prior to intended disposal date.

5.3 As part of the appraisal it needs to be taken into consideration whether temporary extension retention periods need to be considered to support reasonably foreseeable litigation, public inquiries or on-going Freedom of Information request. An example of a temporary extension is **the Independent Inquiry into Child Sexual Abuse (IICSA)** announced by the Home Secretary 7th July 2014. The national directive is not to dispose/destroy Health Records until the Inquiry has concluded – The Inquiry has an initial advised timeframe of 2020. The Inquiry will advise when to resume the destruction of Health Records.

5.4 It is also good practice to obtain evidence of approval to dispose and destroy records. This will be obtained via the HRC at least 4 weeks prior to intended disposal date. The minutes of HRC are submitted to the Audit, Risk & Governance.

5.5 The HRC will be advised when a destruction of Health Records is imminent. Health Records will be destroyed on an annual basis or a quarterly basis, depending on space issues within the library storage areas. A review of practice and any agreed actions will be documented via the minutes. The minutes of the HRC are submitted to the Audit, Risk & Governance.

6.0 Disposal / Destruction

6.1 Paper records must be disposed of and destroyed to an international standard. They must be incinerated, pulped or shredded (using a cross cut shredder) under confidential conditions.

6.2 The Destruction Report Exclusion Rule Table is generated by the Systems Development Team and the HRC informs Systems Development Team of any amendments **(Appendix B)**.

6.3 When using external companies for disposal and destruction, proof needs to be obtained that the company is certified to carry out confidential destruction. The company must also provide proof of destruction (Destruction Certificates).

6.4 Destruction implies a permanent action therefore it is important to keep accurate records of destruction and appraisal decisions.

6.5 HRMT will initiate the physical process of pulling the records from their current storage area for disposal and destruction **(Appendix C)**.

6.6 Health Records previously destroyed have Patient Master Index (PMI) numbers that are active and inactive:

6.7 **Active Numbers:** Health Records chosen for destruction will have an annotation added to the qualifier field: HR DEST'D [MONTH/YEAR] and a Casenote Record Tracking (CRT) record created: HLTH4DEST. The PMI number remains 'active' in the sense it can be re-used for the same patient if the patient re-presents in the future.

6.8 If a patient who has a destroyed record re-presents, the user registering the new referral/adding an inpatient episode to PAS will use the destroyed PMI number and add **REPRESENTED [MONTH/YEAR] after HR DEST'D [YEAR]** in the qualifier field. The patient's 'Destroyed' record will remain in CRT as an audit that previous paper records existed on the PMI number.

6.9 **Inactive Numbers:** As part of a former destruction process, a number of PMI numbers were put to 'inactive' status. Users cannot see inactive numbers when browsing PAS and will register the patient with a new 'H' prefix number which is universal to all three sites. Inactive numbers should not be re-activated and used.

7.0 Monitoring Compliance and Effectiveness

7.1 The destruction of main Health Records will take place at the beginning of each calendar year or on a quarterly basis, depending on storage space issues within the Health Records Libraries. This will be managed by the HRMT with approval by the HRC.

7.2 All other clinical record types created within the Trust and held separately to the Main Health Record will be managed in accordance with departmental/directorate protocol and adhere to the minimum retention periods set out and referred to in this policy.

7.3 The intended disposal and destruction of any clinical record types created within the Trust and held separately to the Main Health Record must be brought to the attention of the HRMT to ensure correct procedures are followed in respect of minimum retention periods/appraisal/communication to destroy and evidence of destruction obtained.

8.0 Associated Documents

8.1 Health Records Management Policy and Strategy (DCP277).

8.2 Health Records Filing Procedures (DCR050).

8.3 Creating and Tracking Health Records Electronically (CRT) Process (DCR036).

9.0 References

9.1 Annex D1: Health Records Retention Schedule (Link) (in section 4.3).

9.2 Health Records Management Policy & Strategy DCP277 (Link) (in section 4.7).

9.3 Government Independent Inquiry regarding Blood/Blood Products (Link) (in section 4.10.2).

9.4 Independent Inquiry into Child Sexual Abuse (IICSA) (in section 5.3).

10.0 Abbreviations

10.1 **ARG** – Audit, Risk & Governance.

10.2 **CRT** – Casenote Record Tracking.

10.3 **HCC** – Hospital Consultants Committee.

10.4 **HRC** – Health Records Committee.

10.5 **HRMT** – Health Records Management Team.

10.6 **IICSA** – Independent Inquiry into Child Sexual Abuse.

10.7 **MAC** – Medical Advisory Committee.

10.8 **PAS** – Patient Administration System.

10.9 **PMI** – Patient Master Index.

11.0 Consultation

11.1 Health Records Committee.

11.2 Systems Implementation Team.

11.3 Head of Oversees Visitors and Private Patients.

11.4 Designated Nurse Safeguarding & Looked After Children.

12.0 Dissemination

Health Records Committee.

13.0 Document History

13.1 The document was next updated on 11/09/07 to include Life Preservation records/Cardiothoracic surgical procedures.

13.2 The document was again updated on 14/01/08 for the inclusion of CABG, Angioplasty, Cardiac Valve replacement & Pacemaker implant patients as *LIFEPs*.

13.3 The document was updated in January, 2010 for the inclusion of elbow & shoulder replacements in the destruction query section.

13.4 The document was updated in August 2010 for the inclusion on the new destruction process whereby records are no longer made inactive on CaMIS PAS so that the PMI number will remain the same if the patient represents after their Health Record has been destroyed.

13.5 The document has now been brought under the Trust Document Control system with version 1.6.

13.6 The document has been amended in March 2012 to exclude patients with a diagnosis of Tuberculosis – codes A15 – A19.

13.7 This document has been amended in December 2017 to exclude patients with a diagnosis of Transient Ischaemic Attack (TIA) / Stroke. ICD10 codes: G430-433 / G438-439 / G450-G459 / 164X / 1600-1639.

13.8 This document has been amended in January 2018 to include reference to the Government's Independent Inquiry into Blood/Blood products provided by the NHS between 1970 and 1995.

1.0 Equality Act (2010)

1.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

1.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

1.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

1.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

Appendix A

EXCLUSION TO DESTRUCTION CHECKLIST

100 Health Records to be checked whilst the pulling of the records identified for destruction are in progress.

CHECK that the records DO NOT contain the following:

- **No current year sticker present on the outer edge of the records**

- **Date of Birth – check that DOB is more than 25 years from current year (destroy children/young people's records in their 26th year if no activity within 8 years)**

- **Orthopaedic divider** – whether patient has had joint replacement surgery
  Has had metal work put in (screws/plates) but has never had this removed

- **Cardiology divider** – if has a pacemaker / had Angioplasty / Cardiac Valve Replacement /has had Coronary Artery Bypass Grafting (CABG)
  CABG will not have been done at this Trust, usually Castle Hill. If any records are found at validation that contains this info, Mark as Life Preservation in the qualifier and put back to file.
  Any **Cardiothoracic surgery** – Life preservation (should have own divider but could be filed under Cardiology

- **Oncology divider** – Oncology pathways are retained for 30 years

- **Medicine divider** –patients who have had Creutzfeldt-Jakob Disease (CJD) or has HIV

- **Medicine Divider / includes Elderly Medicine –** patients who have had a diagnosis/treatment for Transient Ischaemic Attack (TIA) / Stroke

- Any record which has been marked as Permanent Preservation / Life Preservation / Has Medical Legal sticker

- Clinical Trials – this should be noted on clinical alert, these records need checking with the department who is carrying out the trial. (The records need to be kept 2-5 years after trial ended, depending on type of trial)

- Some records do say 'Do Not Destroy' on the front cover – if there is nothing in the records as regards the above exclusions, then these records can be destroyed.

- **Anything found in records which matches the above or not sure about, escalate to the Health Records Management Team Immediately**

Appendix B

DESTRUCTION QUERY RULES

Systems Implementation Team

(Last Update Required – March 2012)

Report Query Rules:

Identifies all Patients with no Activity since data refresh date, 8 years prior to the current year

Exclusions:

- Date of Birth is 25 years to 1st January of the current year
- Has a diagnosis/treatment for cancer (includes Chemotherapy codes)
- Qualifier contains the text 'PERMPL' preserved for litigation purposes
- Qualifier contains the text 'PERMP' permanently preserved
- Qualifier contain the text 'LIFEP' preserved until death
- Has had a hip or knee, shoulder or elbow replacement
- Has a diagnosis of CJD or HIV
- Has undergone organ transplantation
- Has been treated under the Cardiothoracic Surgery speciality code 170 (*LIFEP*)
- Patients have undergone a CABG, Angioplasty, Cardiac Valve replacement or had a pacemaker fitted (Z95%) codes (these will be *LIFEP* patients unless in clinical trial whereby *PERMP* will apply)
- Has Obstetric (501) history
- Exclude patients with a diagnosis of Tuberculosis – codes A15 – A19
- Exclude patient with a diagnosis of Transient Ischaemic Attack (TIA) / Stroke
- (Clinical coding to provide Cancer/chem./CJD/HIV/transplant codes for exclusion)

Appendix C

Destruction Process