Retention and Destruction of Records Policy
(Including Health Records)

Policy information

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Approval information

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Sustainable Resources Committee
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Scope:
This policy has been written as guidance for Hywel Dda University Health Board in dealing with the legal retention and destruction timescales for all clinical and non clinical records and ensuring information is processed and disposed of in accordance with the Data Protection Act /General Data Protection Regulations 2018 or any subsequent legislation to the same effect. Staff working for the Health Board must make every effort to comply with this policy and applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

To be read in conjunction with:
[191] – Health Records Management Strategy – opens in a new tab
[192] – Health Management Policy – opens in a new tab
Records Management Code of Practice for Health and Social Care 2022
[172] – Confidentiality Policy – opens in a new tab
[836] – All Wales Information Governance Policy – opens in a new tab

[347] – Corporate Records Management Policy – opens in a new tab
[224] – Information Classification Policy – opens in a new tab
[837] – All Wales Information Security Policy – opens in a new tab

Patient information:

Owning group:
IGSC31/01/2023

Executive Director job title:
Director of Operations

Reviews and updates:

1. New ;policy September 2012
2. Full review 23.2.2016
3. DPA update 26.6.2018
4. Full review

Keywords
Retention and destruction, health records

Glossary of terms
Records management - is that “field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and [disposal] of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records”. ISO 15489-1: 2016 Information and documentation – Records Management Records management is about controlling the organisation’s records to ensure authenticity, reliability, integrity and usability

Retention Schedule - is a document setting out what records the Health Board holds and how long they will be retained before disposal. It can also be used to set out what needs to happen to records at various different stages of their lifecycle to ensure that they are stored efficiently.

A record - 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 individua*l”. Anything that contains information that has been created or gathered as a result of any aspect of the work of NHS employees

Data Protection Legislation – the term Data Protection Legislation means all applicable laws, regulations and regulatory rules which govern the processing of personal data including (i) the Data Protection Act 2018, Regulation (EU) 2016/679 the UK General Data Protection Regulation (UK GDPR), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (as amended) and any subsequent legislation enacted and duly in force from time to time relating to the processing of Personal Data; and (ii) all guidance and / or codes of practice issued from time to time by the Information Commissioner or relevant government department, and any relevant rulings from time to time of the Information Commissioner or of the Courts of England and Wales relating to the processing of Personal Data.

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Introduction

The Public Records Act 1958 requires that there is a systematic and planned approach to the management of records within an organisation. NHS organisations have a statutory duty to make arrangements for the creation, safekeeping and eventual disposal of all such records, which ensures that the Health Board has access to reliable information. Records are a valuable resource because of the information they contain and the Health Board needs to maintain information in a manner that effectively serves its own business needs, those of the patient and to dispose of the information efficiently when no longer required.

High quality information underpins the delivery of high quality evidence based healthcare and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when needed. An effective records management service ensures that all records and information is appropriately managed in line with legal requirements and is available whenever and wherever there is a justified need for that information, in whatever form of media it is required.

The key statutory requirement for compliance with records management principles is the Data Protection Act 2018 / UK General Data Protection Regulation 2016 or any subsequent legislation to the same effect. It provides a broad framework of general standards that have to be met and considered in conjunction with other legal obligations. The Acts regulate to the processing of personal data, held both manually and on computer. It applies to personal information generally, not just to health records.

Policy Statement

This policy complies with the Welsh Government National Guidance: Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records.

The Code is a guide to use in relation to the practice of managing records. It is relevant to organisations working within, or under contract to, the NHS in Wales and provides a framework for consistent and effective records management based on established standards and current legislation. It includes guidelines on topics such as legal, professional, organisational and individual responsibilities when managing records. It also advises on how to design and implement a records management systems including advice on organising, storing, retaining and deleting records. It applies to all records regardless of the media they are held on.

This Code replaces the previous guidance: WHC 2000 (71): For the record – Managing Records in NHS Trusts and Health Authorities.

Individual members of staff are responsible for any records they create or use and all organisations and managers need to enable staff to conform to this policy and the standards of the code.

Scope of policy

This policy is provided to Hywel Dda University Health Board to deal with the legal retention and destruction timescales for all clinical and non-clinical records and ensuring information is processed and disposed of in accordance with the Data Protection Legislation or any subsequent legislation to the same effect.

Staff working for the Health Board must make every effort to comply with this policy and it applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

Aim

The policy will provide a framework within the Health Board to ensure compliance with Welsh Government National Guidance: Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records.

The Health Board has an individual responsibility to retain all records securely, in line with legal timeframes. The aim of the policy is to ensure that retention periods for health records are maintained in accordance with Statute law. The policy will underpin all operational procedures and provide assurance and assistance to staff in terms of activities connected with the retention and destruction of records.

Objectives

The objectives of the policy are to provide all Health Board staff with clear guidance and standards to attain on a daily basis and provide robust assurance in regards the retention and destruction of sensitive and confidential patient information. The policy will ensure:

- All records are only retained for the minimum and legal timescales.
- Clearly appraised, validated and culled in line with guidance and best practice.
- Provide assurance that only relevant and appropriate records are destroyed.
- All records are destroyed in a confidential manner.
- Provide simplistic reference points for staff to identify retention periods for both clinical and non clinical records.
- Used as a service guide for all areas to comply with retention periods.
- Utilised as a guide for effective working and storage management.

What is a Record

There are a couple of definitions of a record, which are useful to highlight.

The ISO standard ISO 15489 – 1:2016 defines a record as:

- Information created, received and maintained as evidence and as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business.

Section 205 of the Data Protection Act 2018 defines a health record as a record which:

- Consists of data concerning health.
- Has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom it relates.

Records Management applies to any material that holds information gathered as part of the work undertaken in the NHS. A health record can be anything that contains information and has been gathered and created as a result of any aspect of the work of NHS employees – including management consultant agency or bank/agency staff. It will included decisions which relate to the physical and mental health of an individual which has been made by or on behalf of a health professional.

There will be a wide range of record formats and that will include both physical and digital records**.** Only relevant records that are utilised by Hywel Dda staff to undertake their daily duties, should be managed

through this policy and in line with the guidance provided in Appendix ii and iii of the Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records. A link to the Code of Practice is provided in the retention timescales section below.

Retention

Access to the health record is essential to the delivery of effective patient care. Patient health records must therefore be retained securely for the whole period that the patient is receiving active treatment and must be easily retrievable from either internal or offsite storage, whenever they are required by a clinician.

It is important to note that prior to relocating any records to a non Health Board storage provider/facility these proposals should be outlined and discussed with both the Health Records Manager and the Information Governance Service. Only approved Third Party Providers should be used.

This policy details the legal minimum recommended periods for the retention and destruction of records. Health Board staff will be responsible for complying with the minimum retention periods and providing assurances that retention timescales are being applied and adhered to, following the conclusion of treatment. The recommended minimum retention periods apply to both paper and digital records.

Destruction

All organisations have a responsibility to dispose of records at the end of their lifecycle, which is usually at the end of the retention period. Normally an appraisal will be completed, to decide what to do with the records, once their business need has ceased and the minimum retention period has been reached. Paper records selected for destruction and can be destroyed either in-house or under contract with an approved provider. If an external provider is used, the health organisation is responsible for ensuring the chosen provider meets the necessary requirements.

A record should be maintained and preserved confirming the destruction of records, showing their reference, description and date of destruction, so that the organisation is aware of those records that have been destroyed and are therefore no longer available. Disposal schedules would constitute the basis of such a record.

All records falling into the category of being selected for destruction will be destroyed after meeting relevant criteria, such as:

- All retention categories have been complied with
- Records will be identified either by manual or computer methodology
- All Hywel Dda University Health Board systems have been checked for most recent activity
- Records will be physically checked to ensure that there are no entries relating to a later date
- Records will be marked as destroyed on the relevant computer systems on which details of the patient records are held e.g. Welsh Patient Administration System (WPAS)
- Records for destruction will be destroyed in accordance with the appropriate Confidential Waste Process.

Legislation

This policy and the guidelines provided take into account and 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. The Health Board and Managers within services must ensure staff are also aware and familiar with such laws, guidance and governance principles.

Responsibilities

Records management should be recognised as a specific corporate responsibility within every organisation. It should provide a managerial focus for records of all types, in all formats throughout their lifecycle, from creation through to ultimate disposal. The records management function should have clear responsibilities and objectives and be adequately resourced to achieve them.

The Chief Executive has overall accountability for ensuring the effective implementation of this policy and ensuring records are retained securely and disposed of in a timely and confidential manner, in accordance with the identified legal guidance and information governance standards. The Chief Executive may delegate responsibility for management and organisation of retention and destruction service to a designated Executive/Caldicott Guardian who is responsible for ensuring appropriate mechanisms are in place to support service delivery and continuity.

The Health Records manager has professional and operational responsibility for the security, retention and destruction of health records ensuring practices within the organisation are managed in accordance with legal timescales and that related policies and procedures conform to the latest legislation and standards. The Health Records Manager is accountable for ensuring only appropriate records are destroyed and for reviewing destruction processes to maintain confidentiality at all times

All Health Board staff have an individual responsibility for the records they create and use. All staff must ensure all records and patient information, which is extremely confidential is destroyed by utilising the confidential waste process available to them and in line with Health Board standards.

Training

All staff employed by the NHS in Wales will receive information on their personal responsibilities for record keeping in contracts of employment. This includes the creation, use, storage, security and confidentiality of health records. Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. All new employees to NHS organisations in Wales will be given basic records practice training as part of the induction process.

Professional standards of record keeping are governed by the associated Royal colleges. These standards should form part of the professional practice review.

Training in the specifics of confidentiality and data protection will be identified through the agreed Information Governance training sessions.

Retention Timescales

Retention timescales can vary quite significantly across the various record types. It is essential that staff only review retention timescales associated with the record types they utilise within their roles and responsibilities within the Health Board. Retention guidance is provided in Appendix ii and iii of the

Records Management Code of Practice for Health and Social Care (opens in a new tab) – A guide to the management of health and care records and information for all Health Board staff on nationally agreed retention guidelines .