Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

# RETENTION, DISPOSAL & DESTRUCTION OF CARE RECORDS POLICY

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| Author/ lead | Catherine Dixon Medical Records Manager<br>Ray Hull Health Informatics Advisor |
| Feedback on implementation to | Care Records Project Group |

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| Date for review | February 2013 |

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| Target audience | All staff belonging to the Trust involved in the management of Care Records |

Policy version

Current version : v5

This policy and the Records Management Policy which underpins it is stored and is available in the Policies section of the SHSC intranet

# Contents:

## 1. Introduction

This policy sets out standards and arrangements governing the retention, disposal and destruction of health and social care records belonging to Sheffield Health and Social Care NHS Foundation Trust.

The Trust recognises the critical importance of keeping records confidential and respects the right of service users to have accurate information stored about them for as long as necessary to meet their health and social care needs. Many service users have long term health and social care needs and so their records may need to be kept securely for many years. The Trust also recognises the human rights aspects of service user confidentiality. It is required **not** to retain personal confidential information longer than needed for the benefit of the service user. The policy provides information for all health and social care staff in the Trust about how long to retain records and the circumstances under which they should be destroyed or retained for long-term storage.

The policy is intended to ensure that health and social care records are retained, disposed of or destroyed in accordance with the NHS Records Management Code of Practice.

It is based on current legal requirements. It will ensure that Sheffield Health and Social Care NHS Foundation Trust fulfils its responsibilities as set out in:-

Records Management: NHS Code of Practice, April 2006
Standards for Better Health Core Standard C9
Information Governance Toolkit
NHS Litigation Authority Risk Assessment for Trusts
Sheffield Health &Social Care NHS Foundation Trust Records Management Policy

This policy will also ensure that records are retained or destroyed in accordance with the Public Records Act 1958, Data Protection Act 1998 and the Freedom of Information Act 2000.

This policy relates solely to care records and does not include corporate or business records.

In cases where a record is held jointly by health and social care professionals the record should be retained for the longest period appropriate for that type of record i.e. if social care has a longer retention period than health then the record should be kept for the longer period. Contact the Trust Care Records Management Lead for information about retention periods for social care records

## 2. Definitions

### Appraisal

This is a process to determine how long records must be kept following closure (this is called the retention period) and how the records will be disposed of at the end of the retention period.

### Care Records

In this policy Care Records refers to health and social care records created by Sheffield Health and Social Care NHS Foundation Trust staff in the course of providing care for its service users. A Care Record is a record containing information relating to a given service

user who can be identified from that information and which has been recorded or received by an authorised practitioner in relation to their treatment.

Destruction

Destruction is the process of eliminating or deleting records beyond any possible reconstruction.

Disposal

Disposal is the implementation of appraisal and review decisions. These comprise the destruction of records and the transfer of custody of records. It also includes the transfer of records from paper to electronic form.

Retention

Retention is the continued storage and maintenance of records for as long as they are required until their eventual disposal.

Review

The examination of records to determine whether they should be destroyed, retained for a further period or transferred to an archive establishment.

## 3. Purpose of this Policy

The purpose of this policy is to ensure that the retention and disposal, including destruction of care records is managed in line with statutory procedures.

The destruction of records is an irreversible act and can have serious consequences. This policy ensures that appropriate controls are in place to prevent irreversible errors in the procedures.

The Retention and Disposal Policy forms part of a framework of standards, policies, procedures and guidance which is being developed to support effective implementation of the Trust's main Records Management Policy.

## 4. Duties

It is recognised that all staff in the organisation have responsibility for ensuring records are retained in line with this policy and that good practice is maintained throughout the organisation.

The Chief Executive has overall responsibility for ensuring that records are managed responsibly within the Trust and that the records management function is recognised as a specific corporate responsibility.

The Board level director with responsibility for health care records management is Liz Lightbown (Executive Director of Nursing and Quality).

The Caldicott Guardian is Mick Rodgers (Executive Director of Finance / Deputy Chief Executive). The Caldicott Guardian is responsible for overseeing the protection and use of

person-identifiable information.

The Trust-wide Records Management Lead for Care Records is Tina Ball (Director of Quality). The Records Management Lead for Care Records is a member of the Information Governance Steering Group and chairs the Care Records Group. The Records Management Lead for Care Records is responsible for working with the Records Management Lead for Corporate/Business Records to co-ordinate records management in the Trust. The Records Management Lead for Care Records is responsible for periodically reviewing this policy, monitoring the effectiveness of its implementation, providing advice and guidance and identifying training needs.

The Care Records Group is a sub group of the Information Governance Steering Group. Its purpose is to support and take forward the Care Records agenda and provide the Information Governance Steering Group with the assurance that secure and effective care records arrangements, policies and procedures are in place within the Trust. It co-ordinates and monitors delivery of work programmes related to care records

Catherine Dixon, Mental Health Act Administrator / Medical Records Manager, is responsible for day to day management of the Trust's Medical Records Library at the Michael Carlisle Centre.

John Wolstenholme, Information Manager, is the Trust's Information Security Officer and is responsible for implementing, monitoring, documenting and communicating information security requirements for the Trust.

Heads of Directorate are responsible for ensuring that the policy is implemented in their individual directorate. Effective implementation will form part of the general governance arrangements for their teams and directorate. They will nominate local representatives who will liaise with the Records Management Lead on the management of records in their local directorate.

All managers are responsible for ensuring that they are aware of their personal responsibilities for records management and for ensuring that their staff are aware of this policy
and their individual responsibilities. This includes covering records management in local induction programmes, personal development plans and identifying and meeting training needs.

## 5. Scope of this Policy

This policy applies to all staff involved in the use and management of a Care Record.

This policy relates to all Trust care records in any format. This includes but is not limited to

- paper/manual records;
- electronic records;
- scanned records;
- microfilm/Microfiche, and
- Photographs, slides and other images including digital,
- audio and video tapes, cassettes, CD-Rom etc.

## 6. Specific details

### 6.1 Closing a Record

The first step in managing records disposal is to ensure that records, whatever their format, are closed when it is appropriate to do so. This is to ensure that the system is not full of inactive records and also that only inactive records are moved out of current recordkeeping systems. There is otherwise a risk that records may be closed but not formally designated as such, in which case they cannot be identified for disposal.

*The record closure process will be carried out by Medical Records Staff.*

In Sheffield Health & Social Care NHS Foundation Trust the criteria for closing a care record will be met when the service user has had no recorded contact with the service within the previous five years or six months after the death of the service user. Manual records should be marked closed together with the date of closure. Electronic records will be flagged as closed with the date of closure.

Immediately after closure of a manual record, or as soon as possible thereafter, all documents forming the manual record will be scanned and stored electronically as part of the Insight record for the particular service user. The Trust's procedure for scanning records into Insight will be followed in all cases. This procedure is available on the Insight Help module.

Once the manual documents have been scanned into the Insight record and have been quality checked in accordance with the Trust's procedure for scanning records into Insight, the manual record will be destroyed. Requirements governing the destruction of records are set out in section 6.5 of this policy

*Electronic care records will be transferred to the 'closed' folder on Insight.*

The process of closing care records should take place at least once a year.

Details of care records closed at each review must be recorded on a Closure and Disposal Schedule, showing record ID (insight & NHS Number), date of closure, name and designation of person authorising closure of the record.

Closed care records need to be marked as such on the Care Records Inventory.

### 6.2 Appraisal

Each care record will be appraised at the time when the record is closed or as soon as possible thereafter.

Appraisal is a two part process; the first part is to decide how long the record must be kept after closure (this is called the retention period): the second part is to decide whether the record can be destroyed at the end of the retention period or whether it has archival value.

*Medical Records Department will be responsible for appraising closed records*

#### 6.2.1 Retention Periods

The Trust will follow the minimum retention periods set out in Annex D of the Records Management: NHS Code of Practice, The Annex provides guidance on the minimum retention

periods for a range of NHS record types. The Code of Practice is available alongside this policy and the main Records Management Policy on the Trust's Intranet.

Sheffield Health and Social Care NHS Foundation Trust creates joint health & social care records. In cases where a record is held jointly by health professionals and by social care professionals the record should be retained for the longest period for that type of record, i.e. if social care has a longer retention period than health, then the record should be kept for the longer period. For further information about social care retention periods please contact the Trust's Records Management Lead for Care Records.

The care records of service users of Sheffield Health & Social Care NHS Foundation Trust will normally be kept for a minimum period of 20 years after the last contact with the service user or 8 years after the death of the person. However, where Sheffield Health and Social Care NHS Foundation Trust staff have been actively involved in child protection issues the retention period for the records of young people may be longer. The Trust's retention schedule is attached at appendix A. The minimum retention period should be calculated from the beginning of the year following the date of the last contact with the service user.

Records should not ordinarily be kept for longer than 30 years after creation. The Public Records Act does however, provide for records which are still in current use to be legally retained.

It is the responsibility of the Trust's Records Management Lead for Care Records to ensure that retention period guidance is kept under review so that any changes can be reflected in the Closure and Disposal Schedules. The guidance must also be kept under review to ensure that any differences between the guidance and local record types can be identified and addressed. Any such differences must be referred to the Trust-wide Records Management Lead for Care Records for resolution by the Care Records Group.

The Trust also acknowledges that there may be a need for longer term retention of all or part of a care record for clinical benefit. This would arise in circumstances where there were long term health conditions and the record is likely to be valuable for future care and treatment of the service user and family.

6.2.2 Records with Archival Value

Records selected for permanent preservation in the archive will be transferred to the archive at the end of the retention period in a secure and confidential manner (see section 6.9 below for details of the transfer process).

Guidelines for the appraisal of records for permanent preservation will be developed jointly by the Trust and Sheffield Archives.

6.2.3 Records with No Archival Value

Records not selected for archival preservation will be destroyed at the end of the retention period in a secure and confidential manner.

6.3 Closure and Disposal Schedule

The Closure and Disposal Schedule is a timetable which gives retention periods and disposal decisions for records.

Disposal decisions following the appraisal process must be recorded in the Closure and Disposal Schedule.

The schedule will include: - the record ID (Insight and NHS numbers), closure date, name and designation of person authorising closure of record, appraisal date, disposal decision and name and designation of person authorising disposal decision.

Disposal decisions will also be recorded in the care records that have been appraised, for example

- Transfer to National Archives after xx years in 20xx , together with a cross reference to the appropriate closure and disposal schedule.

- Destroy after xx years in 20xx, together with a cross reference to the appropriate closure and disposal schedule.

Records that have been appraised must be marked with the disposal decision and due date on the Care Records Inventory.

6.4 Implementation of Closure and Disposal Schedules

The implementation of the Closure and Disposal Schedule will take place no less frequently than once a year and will be the responsibility of the Medical Records Department

A review of closed records will be undertaken to identify those for disposal. Before carrying out the disposal action the following checks will be made:

- the record use history in case it suggests that a record due for destruction has had continuing use or is of archival value after all
- that the trigger for disposal has occurred (usually the date)
- that the record is no longer involved in any action that is not yet complete
- that the Trust is not involved in any legal case or litigation which precludes the destruction of the record
- that the record is not known to be subject to a request for information under the Freedom of Information Act or the Data Protection Act.

Important note:
Under no circumstances must information be destroyed, amended or concealed in order to avoid complying with a request for information, it may constitute a criminal offence for which the person guilty will be personally responsible.

After the above checks have taken place, records which are due for disposal, after the above checks have taken place, should be removed from the system and disposed of according to the procedure in sections 6.5 below (for destruction of records) and 6.6 (for transfer to archives) as appropriate.

6.5 Destruction of Records

Those records due for destruction will, subject to the checks set out in section 6.4 above, be destroyed in a secure and confidential manner.

It is the responsibility of the Trust to ensure that the methods used throughout the destruction process provide safeguards against the accidental loss of the records or disclosure of the contents of the records.

For care records held in paper format to be destroyed effectively whilst retaining confidentiality, only contractors approved by the Trust and with the ability to destroy the records on site will be used. A certificate of destruction must be issued by the contractor and retained in the Medical Records Department.

A record of destruction must be kept of every individual paper care record destroyed.

When paper records are destroyed the Care Records Inventory will need to be updated to show the records have been transferred from paper to an electronic copy.

Procedures for governing the effective destruction of electronic records will be developed

In all cases record destruction documentation must be completed, showing:-

- a list of the records destroyed, including destruction dates
- reference to the Disposal Schedule setting out the disposal decision to destroy
- the name, designation and signature of senior manager authorising the destruction
- evidence of destruction e.g. a certificate of destruction from an external contractor, or details of method and place of destruction together with name, designation and signature of Trust staff carrying out the destruction

Documentation on destroyed records must be kept by the Trust indefinitely

Care records which have been destroyed must be recorded as such on the Care Records Inventory

6.6 Transfers of Records to Archives

Those records due for transfer to the archive will, subject to the checks set out in section 6.4 above, be transferred in a secure and confidential manner as set out below

*Details to be agreed with archives*

Documentation on records transferred to the archive must be completed, showing:-

- a list of the records transferred, including transfer dates
- reference to the Disposal Schedule setting out the disposal decision to transfer to the archives
- the name, designation and signature of the senior manager authorising the transfer
- evidence of receipt by the archive.

Documentation of transferred records must be kept by the Trust indefinitely

Records which have been transferred to the archive must be recorded as such on the Care Records Inventory,

## 7. Dissemination, storage and archiving

The Trust Records Management Lead for Care Records will liaise with the Trust's Integrated Governance Team to ensure that the ratified version of the policy is appropriately placed on the Trust's website within seven days of ratification and that the previous version is removed. The Trust Records Management Lead for Care Records will also liaise with the Integrated Governance Team to ensure that all documents forming part of the framework of standards,

procedures and guidance developed to support implementation of this policy are made available on the website alongside this policy. The Care Record Management Lead will also ensure that the Records Management: NHS Code of Practice is made available on the website alongside this policy.

The Trust's Records Management Lead for Care Records will send a Sheffield Health and Social Care NHS Foundation Trust e-mail alert to all staff, informing them of the revised policy and of its availability on the website.

In addition the Trust Records Management Lead for Care Records will instruct Heads of Directorate to ensure that all teams and areas within their directorate are made aware of the revised policy and of individual responsibilities for records management contained within it.

Heads of Directorate are responsible for ensuring that any previous versions of the policy are removed from any manuals or files stored within their directorate and destroyed. The Trust Records Management Lead for Care Records will collaborate with the Trust's Integrated Governance Team to ensure that an archive of previous versions of this policy is maintained.

The Trust's Records Management Lead for Care Records, working through the Information Governance Steering Group, will assess the need for, and where appropriate develop and implement such communications and awareness programmes necessary to ensure continued awareness of the policy, its provisions, roles, and responsibilities.

## 8. Training and other resource implications

All managers are responsible for ensuring that their staff are aware of their record keeping and records management responsibilities and that they are equipped to fulfil those responsibilities. This will include covering records management in corporate and local induction programmes and by identifying and meeting specific or generic training needs through personal development plans.

The Trust's Records Management Lead for Care Records, working through the Information Governance Steering Group, will ensure that training needs are identified in the annual implementation work programmes. Training and other resource implications will be subject to justification and prioritisation as plans are developed in the annual implementation work programmes.

## 9. Audit, monitoring and review

The Information Governance Steering Group, through authority delegated to the Care Records Group, will ensure that arrangements are established to test compliance of records management procedures and practices with the provisions of this policy and with associated standards, including NHS Litigation Authority Risk Management Standards, Care Quality Commission and Information Governance Toolkit Requirements, in order to identify areas requiring attention in future work programmes.

The Information Governance Steering Group will oversee and sign off the content of annual work programmes to support implementation of the policy, and will monitor actual progress with the programmes.

## 10. Implementation plan

| Objective | Task | Responsible Person | Timescale |
|---|---|---|---|
| Dissemination | Post on Trust Intranet | Records Management Lead for Care Records | Within 7 days of ratification |
| | E-mail alert to all staff | Records Management Lead for Care Records | Within 7 days of ratification |
| | Ensure all staff in directorate teams are aware of this procedure and their responsibilities under it | Heads of Directorates | Within 14 days of ratification |
| Staff training and development | Cover requirement to comply with this procedure in corporate and local induction. | All managers | Ongoing |
| | Identify and meet specific or generic training needs for staff through personal development plans | All managers | Ongoing |
| | Identify unmet training needs for inclusion in annual work programme | Records Management Lead for Care Records working through the Care Records Group | Annual process |
| Staff roles and responsibilities | No requirement for significant changes to job descriptions | | |
| Audit and monitoring | Establish arrangements to test compliance of actual records practice with the requirements of this procedure | Information Governance Steering Group | 2010/2011 |
| | Ensure that areas requiring attention, identified during audit, are included in future work programmes | Information Governance Steering Group | 2010/2011 & annual process thereafter |
| | Monitor actual progress with records management work programmes | Information Governance Steering Group | 2010/2011 & annual process thereafter |
| | Feed back Issues and progress in relation to compliance to the Performance and Information Group as part of the feedback on records management generally. | Information Governance Steering Group | Monthly or as necessary |

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|---|---|---|---|
| Review procedure | Review and update procedure as necessary | Records Management Lead for Care Records | 2 years after ratification or sooner if other changes impact on procedure |

## 11. Links to other policies, standards and legislation

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Further information about records retention and disposal is contained in the Records Management: NHS Code of Practice, Part 2, published by the Department of Health. It is based on current legal requirements for the retention and disposal of care records and underpins this policy. Annexe D1 of the Code sets out retention schedules for health care records.

The Code of Practice is published in two parts and is available on the Trust's Intranet and sits alongside the Trust's Records Management Policy.

The Retention and Disposal Policy forms part of a framework of standards, policies, procedures and guidance which is being developed to support effective implementation of the Trust's Records Management Policy.

A key requirement for compliance with records management principles is the Data Protection Act 1998. The Act regulates the processing of personal data, held both manually and on computer. For any records that contain personal data as defined by the Data Protection Act, consideration should be given to the fifth principle of the Act, i.e. that 'Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes'. Note that transfers of selected records to places of deposit will be covered by Condition 7(1) of Schedule 3 and s.33 of the Data Protection Act 1998. Good records management is also a pre-requisite for compliance with the Freedom of Information Act 2000. The Freedom of Information Act, which applies to all public authorities, is a law giving individuals a general right of access to all types of recorded information held by the Trust. This right of access to information is additional to other rights such as access to personal information under the Data Protection Act. It is important to note that under Freedom of Information legislation the disposal of records – which is defined as a point in their lifecycle when they are either transferred to an archive or destroyed – is undertaken in accordance with clearly established policies which have been formally adopted by the organisation and which are enforced by properly trained and authorised staff.

More information on the application of the Data Protection Act, the Freedom of Information Act and on the records management implications of other legal and professional obligations can be found in Annex C of the Records Management: NHS Code of Practice.

## 12. Contact details

Further information about the content and status of this policy can be obtained from the Trust Records Management Leads.

| *Title* | *Name* | *Phone* | *E-mail* |
|---|---|---|---|
| *Trust Records Management Lead for Care Records* | *Tina Ball, Director of Quality* | *271 6393* | *Tina.Ball@shsc.nhs.uk* |
| *Board level Director for Records Management – Care Records* | *Liz Lightbown, Executive Director of Nursing and Quality* | *271 6713* | *Liz.Lightbown@shsc.nhs.uk* |
| *Caldicott Guardian* | *Mick Rodgers, Executive Director of Finance/Deputy Chief Executive* | *271 6716* | *Mick.Rodgers@shsc.nhs.uk* |
| *Medical Records Manager* | *Catherine Dixon* | *271 8102* | *Cath.Dixon@shsc.nhs.uk* |
| *Information Security Officer* | *John Wolstenholme Information Manager* | *30 50749* | *John.Wolstenholme@shsc.nhs.uk* |
| *Clinical Audit & Knowledge Management Manager* | *Jim Chapman* | *271 8954* | *Jim.Chapman@shsc.nhs.uk* |
| *Director of Information Management and Technology* | *Tom Davidson* | *271 6724* | *Tom.Davidson@shsc.nhs.uk* |
| *Trust Data Protection Officer* | *John Wolstenholme* | *305749* | *John.Wolstenholme@shsc.nhs.uk* |
| *Trust Freedom of Information Lead* | *John Wolstenholme* | *305749* | *John.wolstenhome@shsc.nhs.uk* |

## 13. References


Sheffield Health & Social Care NHS Foundation Trust Records Management Policy
Records Management: Department of Health Code of Practice part 1
Records Management: Department of Health Code of Practice part 2
Public Records Acts 1958 & 1967
Data Protection Act 1998
Freedom of Information Act 2000
Department of Health Standards
Care Quality Commission Standards
The National Archives Model Action Plan for Developing Records Management Compliant with the Lord Chancellor's Code of Practice under section 46 of Freedom of information Act 2000
Retention Guidelines for Local Authorities 2003

**SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST**
**RETENTION SCHEDULE FOR CARE RECORDS**

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Child Protection Register (records relating to) | Retain until the patient's 26th birthday or 8 years after the patient death if patient die while in the care of the organisation | | Destroy under confidential conditions |
| Children and young people (all types of records relating to children and young people) | Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment or 8 yrs 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 the records for a longer period | | Destroy under confidential conditions |
| Clinical psychology | 20 yrs | | See Note 1 |
| Clinical trials (see research records) | For anything not covered refer back to Department of Health Guidelines | | |
| Counselling records | 20yrs or 8 yrs after the patients death | Guidance for best practice: the employment of counsellors and psychotherapist in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 | See note 1 |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| DNA (health records for patients who **did not attend** for appointments as out-patients | Where there is a letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given. So this information is also held elsewhere, retain for 2 years after the decision is made.<br><br>Where there is no letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given. Retain for a period of time appropriated to the patient/speciality eg mentally disordered persons(with the meaning of the Mental Health Act 1983) 20 yrs after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation | | Destroy under confidential conditions |
| Learning difficulties –(record of patients with) NB Specific Learning Difficulty is where a person finds one particular thing difficult but manages well in everything else | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | Royal College of Psychiatrists | Destroy under confidential conditions |
| Learning Disabilities NB a general learning disability is not a mental illness – it is a life-long condition, which can vary in degree from mild to profound | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons within the meaning of the MHA 1983 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | Royal College of Psychiatrists | Destroy under confidential conditions |
| Mental Health Records – Child & Adolescent (includes clinical psychology records) not listed elsewhere in this schedule | 20 years from the date of last contact or until their 25th/26th birthday, whichever is the longer period. Retention period for deceased persons is 8 yrs after death | | Destroy under confidential conditions |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Mentally disordered persons (within the meaning of any Mental Health Act) | 20 yrs after the date of last contact between the patient/client./service user and any heath/care professional employed by the mental health provider, or 8 yrs after the death of the patient/client/service user if sooner.<br><br>NB Mental Health organisations may wish to keep mental health records for up to 20yrs before review. Records must be kept as complete records for the first 20yrs in accordance with this retention schedule but records may be summarised and kept in summary format for the additional 10yrs.<br>The records of all mentally disordered persons(within the meaning of the MHA ) are to be retained for a minimum of 20yrs irrespective of discipline eg occupational Therapy, Speech & Language Therapy, Physiotherapy, District Nursing etc)<br>Social Services records are retained for a longer period. Where there is a joint mental health and social care trust, the higher of the two retention periods should be adopted | Mental Health Act 1983<br><br>Royal College of Psychiatrists | When the records come to the end of their retention period they must be reviewed and not automatically destroyed, such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review |
| Music therapy records | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons9within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |
| Occupational therapy records | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons9within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Orthoptic records | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons9within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |
| Outpatient lists (where they exist in paper format) | 2 years after the year to which they relate | | Destroy under confidential conditions |
| Physiotherapy records | Retain for the period of time appropriate to the patient/speciality e.g. children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons(within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |
| Podiatry records | Retain for the period of time appropriate to the patient/speciality e.g. children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons9within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |
| Psychology records | 20 yrs or 8 yrs after death if patient died while in the care of the organisation | | See note 1 |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Psychotherapy records | 20 yrs or 8 yrs after death if patient died while in the care of the organisation | Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 | Destroy under confidential conditions |
| Records of destruction of individual care records (case notes)and other health-related records contained in this schedule<br><br>(in manual or computer format) | Permanently | BS ISO 15489 (section 9.10) | See note 1 |
| Referral letters for clients referred to health or care services but not accepted | Where there is a letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client. So the information is held elsewhere. Retain for a period of 2years after the decision is made<br><br>Where there is no letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client. Retain for the period of time appropriated to the patient/speciality eg mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation | | Destroy under confidential conditions |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Referral letters where the appointment was cancelled by the patient before the referral letter was included in the patient record (i.e before the clinic preparation process) | Where a letter is sent to the referring clinician detailing the reason(s) why the patient/client cancelled the appointment. Retain for 2 years after the date the appointment was cancelled.<br>Where there is no letter or correspondence detailing the reasons for patient not attending for their appointment that goes to the clinician/organisation that has referred the patient/client. Retain for the period of time appropriated to the patient/speciality eg mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation | | Destroy under confidential conditions |
| Scanned records relating to patient care | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation<br>NB providing the scanning process and procedures are compliant with BSI's BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically once the casenotes have been scanned the paper records can be destroyed under confidential conditions | | Destroy under confidential conditions |
| Speech & Language Therapy notes | Retain for the period of time appropriate to the patient/speciality eg children's records should be detained as per the retention period for the records of children and young people; mentally disordered persons within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died whilst in the care of the organisation | | Destroy under confidential conditions |
| Suicide – notes of patients having committed suicide | 10yrs | See note 1 | |

| Type of Record | Minimum Retention Period | Derivation | Final Action |
|---|---|---|---|
| Video records/voice recordings relating to patient care/video records/video conferencing records related to patient care/DVD records relation to patient care | Children & Young People:<br>Records must be kept unit the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday or until 8 yrs after the patient's death if sooner<br><br>Mentally disordered person :<br>mentally disordered persons within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died | | The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. |
| Vulnerable Adults | Mentally disordered persons within the meaning of the MHA 1983) 20 yrs after the last entry in the record or 8 yrs after the patient's death if patient died | | |
| Ward registers, including daily bed returns (where they exist in paper format | 2 years after the year to which they relate | | May have archival value |

Note 1 – Sheffield Archives is the Approved Place of Deposit and should be consulted in the first instance
Taken for Department of Health Guidelines
In case of notes not referred to above please refer to the Department of Health Guidelines

# Appendix B Equality impact assessment form

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| | • Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | N/A | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | N/A | |
| **5.** | **If so can the impact be avoided?** | N/A | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |

If you have identified a potential discriminatory impact of this procedural document, please refer it to Liz Johnson (Head of Patient Experience, Inclusion and Diversity) together with any suggestions as to the action required to avoid/reduce this impact.

# Appendix C (Continued) Human Rights Act Assessment

**1.1 What is the Policy title?**

Retention, Disposal & Destruction of care Records Policy

**1.2 What is the objective of the Policy?**

The policy defines a structure for the Trust to ensure that health and social care records are retained, disposed of or destroyed in accordance with legal requirements. It ensures that the Trust can control the retention, disposal or destruction of care records through managed process.

**1.3 Who will be affected by the Policy?**

The policy applies to all people working on Trust business. It includes, for example, all staff, whether directly employed, seconded, on honorary contracts, permanent or temporary, also agency staff, non executive directors, students and others working under contract to the Trust.
The policy is relevant to people who currently use Trust services or who have used Trust services in the past, as the policy relates to the management of records that contain personal information.

**2.1 Will the Policy engage anyone's Convention Rights?**

The following Convention Rights are potentially engaged :-
Article 8 : Right to respect for private and family life – this is a qualified Right.
Article 10 : Freedom of expression – this is a qualified Right.

**2.2 Will the Policy result in a restriction of a Right?**

The policy is intended to provide assurance in respect of Records Management. The policy has been developed in line with statute and national guidance. As long as the policy, procedures and guidance relevant to the policy are adhered to there will be no restriction on Convention Rights associated with this policy. The policy provides for this in the process of implementation.

# Appendix D

## Development and consultation

This policy was developed through the Care Records Group in line with the requirements of

Records Management: NHS Code of Practice, April 2006
Standards for Better Health Core Standard C9
Information Governance Toolkit
NHS Litigation Authority Risk Assessment for Trusts
Sheffield Health &Social Care NHS Foundation Trust Records Management Policy

This is the first version of this policy and went out for consultation on the 16 September 2010. The distribution list was agreed by the Care Records Group and included

Danitza Jadresic. Consultant
Tina Ball, Director of Quality
Tony Flatley, Lead Nurse
Stephen Jones, CPA Manager
Julie Leeson, Director of Therapy Services

The above were asked to forward the draft policy and the electronic questionnaire on to their colleagues inviting them to participate in the consultation.

Also invited to participate in the consultation were :-
Service users
Alick Bush, Clinical Director, Learning Disabilities Services
Josie Bennett. Service Director, Learning Disabilities Services
Katy Kendal, Clinical Director, Recovery, Rehabilitation and Specialist Services
Guy Hollingsworth, Service Director, Recovery, Rehabilitation and Specialist Services
Rachel Warner, Clinical Director, Acute, Community and Primary Care Services
Richard Bulmer, Service Director, Acute, Community and Primary Care Services
Peter Bowie, Clinical Director, Dementia Services
Ellen Hobson, Service Director, Dementia Services
Olawale Lagundoye, Clinical Director, Drug and Alcohol Services
Michelle Fearon, Head of Service, Drug and Alcohol Services
Fiona Goudie, Clinical Director, FMI and Community Services
Jeannette Hensby, Service Director, FMI and Community Services
Gwyneth DeLacey, Director of Psychological Services
Peter Pratt, Chief Pharmacist

The draft policy was sent to OMG for comment on 23 December 2010.

Feedback from service users has been taken into account where appropriate. No other feedback requiring amendment of the policy has been received.

The draft policy was discussed at the Care Records Group meeting held on 12 January 2011, the Information Governance Steering Group held on 19 January 2011 and the Performance and Information Group held on 20 January 2011.

Approval to submit the draft policy to the Executive Directors' Group for ratification was given at the Performance and Information Group on 20 January 2011.