Trust Policy and Procedure Document Ref. No: PP(24)192

Records Retention, Storage & Disposal

For use in:	**All Areas**
For use by:	**All Staff Members**
For use for:	**Guidance to Staff on Records, Retention Storage & Disposal**
Document owner:	**Head of Information Governance**
Status:	**Approved**

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This Policy is drawn from the Department of Health,
Records Management Code of Practice for Health and Social Care 2021

Aim

The aim of this policy is to clearly define the Retention, Storage, Retrieval, Disposal and Destruction processes for West Suffolk NHS Foundation Trust (WSH) for both paper and electronic records so that records are not kept longer than they are needed.

The Department of Health Records Management NHS Code of Practice for Health and Social Care 2021, identifies minimum retention periods for NHS records, on which this policy is based.

The retention schedule lists records alphabetically as part of a particular function. The corporate records schedule has grouped together records of major functions commonly found in NHS organisations

Records Management NHS Code of Practice for Health and Social Care 2021
https://transform.england.nhs.uk/information-governance/guidance/records-management-code/

Types of Record covered by this Code of Practice

The guidelines contained in this Code of Practice apply to NHS records of all types regardless of the media on which they are held, including:

Function:
- Patient health records (electronic or paper based, including those concerning all specialties and GP records)
- Records of private patients seen on NHS premises;
- Accident & Emergency, Birth, and all other Registers;
- Theatre Registers & Minor Operations (and other related) Registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records; notes associated with complaint-handling);
- X-Ray and Imaging reports, output and images;
- Integrated health and social care records;
- Data processed for secondary use purposes.

Format:
- Photographs, slides, and other images;
- Microform (i.e. microfiche / microfilm);
- Audio and videotapes, cassettes, CD-ROM etc;
- MS Teams recordings;
- E-mails;
- Electronic records;
- Scanned records;
- Text messages and social media;
- Websites and intranet sites that provide key information to patients and staff.

Record Creation

Each department of the Trust must have in place a process for documenting its activities. This process must take into account the legislative and regulatory environment in which the department operates.

Records of operational activities must be complete and accurate in order to allow employees and their successors to undertake appropriate actions in the context of their responsibilities, to facilitate an audit or examination of the Trust by anyone so authorised, to protect the legal and other rights of the Trust, its patients, staff and any other people affected by its actions, and provide authentication of the records so that the evidence derived from them is shown to be credible and authoritative.

Records created by the Trust must be arranged in a record-keeping system that will enable the Trust to obtain the maximum benefit from the quick and easy retrieval of information. Trust business records (electronic) must be kept on a shared drive, for ease of access by those entitled to have access.

Record Keeping

The record-keeping system, whether paper or electronic, must include a documented set of rules for referencing, titling, indexing and, if appropriate, security marking of records. These must be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

Review of Records

All Trust departments must have procedures in place for reviewing and managing records, and for recording disposal decisions. Records are reviewed to determine whether or not they are worthy of permanent preservation, whether they need to be retained for a longer period or whether they must be destroyed. Review dates must be indicated on document footer.

Retention of Medical/Clinical Records

For the purpose of this policy a ‘record’ is anything that contains information (in any media), which has been created or gathered as a result of any aspect of the work of Trust employees, including consultants, agency or casual staff.

The use of health records as a legal document places specific requirements upon the Trust to meet minimum periods of retention. The length of retention depends upon the type of record and its importance to the business of the organisation.

Record Closure

Records must be closed as soon as they have ceased to be in active use, other than for reference purposes. An indication that a file of paper/electronic records has been closed must be shown on the record itself as well as noted in the index or database of the files/folders.

Disclosure and Transfer of Records

There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties and, similarly, a range of provisions that require disclosure. The key statutory requirements can be found in Records Management Code of Practice Part 1. If staff are unsure of the procedure, they must contact their line manager, or the Head of Information Governance for advice.

The Caldicott Guardian (Medical Director) or Head of Information Governance must be involved in any proposed disclosure of confidential patient information. The Head of

Information Governance or Health Records Medico-Legal Co-coordinator will advise on Subject Access requests by members of the public.

Storage of Records

Records in current use are to be stored on Trust premises as agreed with the Health Records Manager or Head of Information Governance.

Each department will comply with this policy, outlining retention, storage and destruction of records. Departments and wards managers will have responsibility for the policy procedure.

Directorates and Departments are responsible for their own storage/filing system. Electronic records must be stored on a Shared Drive and not 'H' Drive. Records which need to be retained outside the Directorate/Department must liaise with the Health Records Manager.

All Trust records are subject to disclosure under the Freedom of Information Act 2000 and, therefore, must be kept up to date and easily retrieved.

Action will be taken to protect records from risk of fire, flood, damp, humidity, pest attack and general damage.

Microsoft Teams Recordings

Audio and visual records can take many forms such as using a dictaphone to record a session or conducting a health or care interaction using videoconferencing technologies – usually Microsoft (MS) Teams. The following needs considering when patient or service user interactions are captured in this way:

- **Clinical appropriateness**: It is acknowledged that MS Teams recordings can be used in a variety of ways across the Trust, both for patient care in the form of recording of MDT discussions, or for meetings with families during a complaint PALS, or inquest enquiry. Each department is responsible for deciding when it is appropriate to use audio or visual methods for the provision of health or care and if in doubt, advice should be sort from the Information Governance team who can be contacted via email info.gov@wsh.nhs.uk.
- **Retention**:
  - If the recording is going to be kept elsewhere (for example, as part of the health and care record) then there is no reason to keep the original recording provided the version in the main record is the same as the original or there is a summary into words which is accurate and adequate for its purpose.
  - If the recording is the only version or instance of the interaction, then it must be kept for the relevant retention period outlined in the NHS Records Management Code of Practice, for which see further below re destruction of records.
- **Digital continuity**: You must consider the medium on which the recording is made and ensure that it is available throughout its retention period (for example, if the system or file format is becoming obsolete, then you will need to migrate it to a newer platform or format to ensure availability). If it is a digital recording and you are looking to store it in the health and care record, ensure the transfer process captures the authenticity of the recording kept.

Access to Records

- Health Records. Application via Medico–Legal Co-ordinator
- Corporate Records. Requests for information under Freedom of Information (see Policy PP155) via Information Governance team.

Record Selection – For Archiving or Disposal

The Health Records Manager and the Head of Information Governance, in conjunction with Corporate Managers, will select records for permanent preservation and the periods for which other records must be retained.

There are currently two national Public Inquiries ongoing: The Infected Blood Inquiry and the Covid-19 Inquiry. Before any records relating to these Inquiries are destroyed, you must check with the Head of Information Governance that they are no longer required. If you are in doubt regarding records that may or may not be of use for an inquiry, you must retain them until there is clear instruction to delete them. .

Records selected for permanent preservation and no longer in regular use by the Trust must be transferred as soon as possible to an archival institution that has adequate storage and public access facilities.

Records not selected for permanent preservation and which have reached the end of their administrative life must be destroyed in the confidential waste bins.

If a record due for destruction is known to be the subject of a request for information, destruction must be delayed until disclosure has taken place or, if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted.

Responsibility

All Corporate and Senior Managers are responsible for their own areas for compliance:

- Records Management Code of Practice for Health & Social Care 2021
- Records Management Strategy
- Health Records Policy
- Local procedures for storage, closure, retention and disposal of health and corporate records

Destruction of Records

Most records contain sensitive or confidential information and it is, therefore, vital that confidentiality is safeguarded at every stage and that the method used to destroy records is fully effective and secures their complete illegibility.

In accordance with the Records Management Code of Practice for Health and Social Care 2021, records must be shredded, pulped or incinerated and a certificate of destruction issued.

All confidential waste paper collected in the Trust is to be destroyed in the correct manner. The Trust has contracted a third party supplier to provide on-site shredding for confidential waste. All paper containing confidential information must be placed in the BLUE BINS.

A certificate of destruction will be sent to the Trust as proof of destruction.

Electronic records should be destroyed following approval by the Head of Information Governance in line with the Information Security Policy PP(xx)060.

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Equality Assessed	Yes
Implementation	Policies will be checked by IG Manager. Policy number will not be issued and policy not approved unless standard contained in this policy are met
Monitoring: (give brief details how this will be done)	Audits will be carried out on Record retention and disposal in line with DH Code of Practice. Compliance with IG Requirements (level 2 or above in all requirements)
Other relevant policies/documents & references:	• WHC (2000) 71: Managing Records in NHS Trust • Records Management Code of Practice for Health and Social Care 2021 • DPA 2018
Additional Information:	