Northern Lincolnshire and Goole Hospitals actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the “protected characteristics” as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.
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1.0 Purpose

1.1 The aim of the policy is to establish a framework through which the Trust is able to meet its statutory obligations for the safekeeping and eventual disposal of Patient Health Records.

1.2 All NHS records, including Personal Health Records are public records under the terms of the Public Records Act 1958.

1.3 Under the Act, and in accordance with Controls Assurance, the Trust has a statutory duty to make arrangements for the retention, preservation and/or destruction of such records. These arrangements are required to take into account the Trusts Risk management policy and strategy.

1.4 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 all Trust clinical/health records – it does not apply to non-clinical records- please refer to the Trust Non-Clinical Records Strategy for further information.

3.0 Duties

3.1 It is the responsibility of the Groups to inform the MRC Chairman of any patient diagnoses or surgical procedures that require preservation longer than the minimum retention period.

3.2 It is the responsibility of all Clinicians and custodians of the Trust’s Health Records to adhere to the requirements of this policy.

3.3 It is the responsibility of the Corporate Health Records Library to validate all destruction lists prior to any Trust Clinical Records are sent for destruction.

4.0 Retention Periods

4.1 Personal Health Records need to be retained for minimum periods to take account of The Limitation Act 1995 and The Congenital Disabilities (Civil Liability) Act 1976.

4.2 The minimum retention periods for Personal Health Records whether paper based or electronic, held by the Trust is given in the Table below:
<table>
<thead>
<tr>
<th>Register / Record Type</th>
<th>Minimum Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Patient Case Records (Paper and Electronic Format)</td>
<td></td>
</tr>
</tbody>
</table>
| **Maternity (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)** | 25 years after the birth of the last child  
Detailed operational policy held within Women & Children’s Group |
<p>| To include:                                                                         |                                                                                          |
| 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                                        |                                                                                          |
| Post natal records (Hospital and Community) of both mother and baby                  |                                                                                          |
| <strong>Children and Young People</strong>                                                        | Until 25&lt;sup&gt;th&lt;/sup&gt; birthday or 26&lt;sup&gt;th&lt;/sup&gt; if young person was 17 at conclusion of treatment; or 8 years after patient’s death if death occurred before 18&lt;sup&gt;th&lt;/sup&gt; birthday |
| <strong>Mentally Disordered Persons (within the meaning of The Mental Health Act 1983)</strong>  | 20 years after no further treatment considered necessary; or 8 years after the patient’s death if the patient died while still receiving treatment |
| <strong>Oncology (including radiotherapy &amp; chemotherapy)</strong>                                  | 30 years (including deceased)                                                            |
| N.B. records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes |</p>
<table>
<thead>
<tr>
<th>Register / Record Type</th>
<th>Minimum Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical trials of investigational medicinal products – health records of participants that are the source data for the trial</td>
<td><strong>Trials to be included in regulatory submissions</strong> – at least two years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, 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.</td>
</tr>
<tr>
<td>Donor Records (blood &amp; tissue)</td>
<td>30 years post transplantation (including deceased patients)</td>
</tr>
<tr>
<td>All other Personal Health Records</td>
<td>8 years after conclusion of treatment or death</td>
</tr>
<tr>
<td>X-Ray Films</td>
<td>7 years after last X-Ray was taken (including deceased records)</td>
</tr>
<tr>
<td>Deceased Patient Records</td>
<td>8 years post date of death unless otherwise indicated for other record types e.g. cancers</td>
</tr>
<tr>
<td>A &amp; E Records (where these are stored separately from the main health record)</td>
<td>Retain for the period of time appropriate to the patient/specialty e.g. Children’s A&amp;E records should be retained as per the retention periods for the records of children and young people</td>
</tr>
<tr>
<td>Ambulance Records</td>
<td>10 years (including deceased patients).</td>
</tr>
<tr>
<td>Asylum Seekers and refugees (NHS personal health record – patient held record)</td>
<td>Special NHS record – patient held – no requirement to NHS to retain</td>
</tr>
<tr>
<td>Creutzfeldt–Jakob Disease (CJD)</td>
<td>30 years from the date of diagnosis, including deceased patients</td>
</tr>
<tr>
<td>Death – Cause of, Certificate counterfoils</td>
<td>2 years</td>
</tr>
<tr>
<td>Allied Health Professional records and Medical Illustrations (if stored separately from the main health record)</td>
<td>Retain for the period of time appropriate to the patient/specialty, EG children’s records should be retained as per the retention period for the records of children and young people</td>
</tr>
<tr>
<td>Register / Record Type</td>
<td>Minimum Retention Period</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Records related to investigation or storage of specimens relevant to organ transplantation, semen or ova</td>
<td>30 years (including deceased records)</td>
</tr>
<tr>
<td>Clinical Audit Records</td>
<td>5 years</td>
</tr>
<tr>
<td>Hospital acquired infection records</td>
<td>6 years</td>
</tr>
<tr>
<td>Patients who have undergone Cardiothoracic Surgery</td>
<td>For the lifetime of patient – 8 years post death</td>
</tr>
<tr>
<td>CABG, Angioplasty, Cardiac Valve Replacement surgery and Pacemaker fittings</td>
<td>For the lifetime of the patient – 8 years post death</td>
</tr>
<tr>
<td>Patients who have undergone Hip/Knee/Shoulder or Elbow replacements</td>
<td>For the lifetime of the patient – 8 years post death</td>
</tr>
</tbody>
</table>

4.3 Please follow that attached link for the retention periods of all Clinical Health Records [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093027.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093027.pdf)

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

4.5 Personal Health Records of individual patients will not normally be preserved permanently under The Public Records Act 1958. In the rare event of a Personal Health Record deemed worthy of permanent preservation, Consultant Medical Staff/Clinical Practitioner should annotate the record appropriately. In these cases the original 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).

4.5.1 If there is a request for Permanent Preservation of a patient’s records, the requesting Clinician or nominated deputy should contact the Corporate Health Records Library and request that the electronic PAS record be recorded for Permanent Preservation.

4.5.2 There are two types of ‘Preservation’ – those that require preservation 8 years beyond death, such as Research Clinical Trials patients and those that require preservation 8 years post death which apply to those who have had a diagnosis/procedure that may require review in the future (beyond 8 years with no activity).

4.5.3 For ease of identification of these records on the Patient Administration System, the Corporate Health Records Library will record in the Qualifier field on PAS the words “PERMP” e.g. for Clinical Trials and “LIFEP” for those records which require preservation until death (local deceased destruction criteria will then apply). It is the responsibility of the requesting clinician to request “PERMP” or “LIFEP” status and indicate the reason for the preservation.
4.5.4 It is the responsibility of the requesting Clinician (or nominated deputy) to ensure the health record folder is annotated inside the records on the ‘Health Record Alert Sheet’ the reason for Preservation and signed by the clinician. The Health Records folder should have a PP (Permanent Preservation) or a LP (Life Preservation) Sticker affixed to the front (these are available from the Corporate Health Records Libraries on each site).

4.6 Personal Health Records of Private Patients admitted 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. The record of attendance will need to be recorded on the Patient Administration System (PAS) in order to ensure retention.

4.6.1 Off-site private patient attendances will not be recorded on the Trust’s PAS system. If a clinician utilises the Trust’s Health Records for off-site Private Patient attendances, the clinician must keep their own copy of the episode documentation as it cannot be assumed that the health records will be preserved. If a consultant wishes particular records to be kept for permanent preservation due to Private Patient attendances, they must follow step 4.4 above.

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

4.8 The minimum retention period for such registers and activity reports held by the Trust is given below:

<table>
<thead>
<tr>
<th>Register / Record Type</th>
<th>Minimum Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency (paper format)</td>
<td>8 years after the year to which they relate – (however likely to have archival value)</td>
</tr>
<tr>
<td>Admission Books</td>
<td>8 years after the year to which they relate – (however likely to have archival value)</td>
</tr>
<tr>
<td>Child Protection Register (records relating to)</td>
<td>Retain until the patient’s 26th Birthday</td>
</tr>
<tr>
<td>Discharge Books (where they exist in paper format)</td>
<td>8 years after the year to which they relate – (however likely to have archival value)</td>
</tr>
<tr>
<td>Mortuary registers (paper format)</td>
<td>10 years (however likely to have archival value)</td>
</tr>
<tr>
<td>Operating Theatre</td>
<td>8 years after the year to which they relate – (however likely to have archival value)</td>
</tr>
<tr>
<td>Birth Register</td>
<td>Permanent preservation</td>
</tr>
<tr>
<td>Blood bank register</td>
<td>30 years to allow full traceability of all blood products used</td>
</tr>
<tr>
<td>Post Mortem register</td>
<td>30 years (however likely to have archival value)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>2 Years</td>
</tr>
<tr>
<td>Patient Activity Data</td>
<td>3 Years</td>
</tr>
</tbody>
</table>
5.0 Destruction of Personal Health Records and Litigation

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

5.2 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.

5.3 Where Personal Health Records are identified as having been/are being used in cases of litigation, reference must be made to the Legal Services Department before destruction.

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

6.0 Destruction Management

6.1 The Medical Records Committee will be advised each year of the annual destruction programme. A review of this programme and any agreed actions will be documented. The minutes of the Medical Records Committee are submitted to the Trust Governance Committee.

6.2 The destruction of Personal Health Records will always ensure that their confidentiality is fully maintained.

6.3 The destruction of confidential Personal Health Records and patient activity data will be by incineration, pulping or shredding. Contractors used to undertake the destruction process will be certified to do this type of work, and a certificate of compliance will be issued and held within the Trust each time a Contractor is engaged.

6.4 Where Personal Health Records have been destroyed PAS/ICRS will be annotated appropriately.

6.5 Once a patient’s record has been destroyed the PMI number will remain active so that if the patient represents the PMI number will remain the same. The patient will have a destroyed record created on CRT. This record will no longer exist but highlight users to the fact that the patient has had a Health Record destroyed. A new Health Record will be created if the patient represents with the existing PMI number and the following sentence will be added into the PAS secondary field

HR DEST’D (YEAR). REPRESENTED (MM/YY), NEW HR CREATED.
6.6 Please refer to appendix A for the full process.

6.7 As part of the destruction annual programme, all PMI numbers that have been put to inactive will be sent to other Information System Managers. The System managers will map inactive numbers to records held within their system e.g. A&E, RIS, Pathlinks, and Tomkat etc.

6.8 If a patient has a ‘Living Will,’ a copy should be submitted to the Corporate Health Records Library who will insert the ‘Living Will’ into the Patient’s Health Record Folder. The Corporate Health Records Library will insert “LIFEP” in the Qualifier field on CAMIS. An ‘LP’ sticker will be affixed to the front of the records folder.

7.0 Monitoring Compliance and Effectiveness

7.1 The destruction programme of main health records will take place at the beginning of each calendar year. This will be managed by the Corporate Health Records Library in conjunction with Information and approved by the Medical Records Committee.

7.2 All other clinical record types created by the Trust will be managed in accordance with departmental protocol and in compliance with this policy and national guidance.

8.0 Associated Documents

8.1 Health Records Management Strategy (SDP010).

8.2 Single Health Record Filing Guidelines (SDR007).

8.3 Creating, Tracing and Tracking Health Records Electronically (CRT) (SDR011).

9.0 References


10.0 Definitions

10.1 HCC – Hospital Consultants Committee.

10.2 MAC – Medical Advisory Committee.

10.3 MRC – Medical Records Committee.

10.4 PAS – Patient Administration System.

11.0 Consultation

11.1 Medical Records Committee.
12.0 Dissemination

12.1 Medical Records Committee.

13.0 Document History

13.1 The document was updated on 30/08/07 to incorporate new national guidelines and identify new Health Record Types and their retention periods. Changes to retention periods for Oncology and donor records. Update to preservation of Private Patient records.

13.2 The document was next updated on 11/09/07 to include Life Preservation records/Cardiothoracic surgical procedures. Inclusion of a section on ‘Living Wills’. Includes monitoring and effectiveness section/duties and scope.

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

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

13.5 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.

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

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

The electronic master copy of this document is held by Document Control, Office of the Medical Director, NL&G NHS Foundation Trust.
Appendix A

DESTRUCTION QUERY

Deceased Patient Query

Identify all Patients who have died before 01/01/2000 (increments by 1 each year) – exclude the patients whereby the Qualifier field contains the Text ‘PERMP’ for permanent preservation, or the patient has a diagnosis of CJD or a Cancer Diagnosis (to be confirmed).

If the patient has *LIFEP* in the Qualifier field on PAS, their records will be kept for the lifetime of the patient and up to 8 years post death.

Live Patient Query

Identify all Patients with no Activity since 01/01/2000.

Exclude where patient:

- Has a Date of Birth post 01/01/1982
- Has had a diagnosis/treatment for cancer (includes chemotherapy codes)
- Has taken part in a Clinical trial. Patients to be marked as Permanent Preservation
- Has had a hip or knee, shoulder or elbow replacement
- Records marked as permanent preservation
- Has a diagnosis of CJD or HIV
- People who have 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 since 1983
- Exclude patients with a diagnosis of Tuberculosis – codes A15 – A19
- (Clinical coding to provide Cancer/chem./CJD/HIV/transplant codes for exclusion)
Appendix B

Destruction Process

1. Print list of records for Destruction
2. Management to test Data (spot checks)
3. List to be passed onto Destruction pulling team
4. Pull records from the Library
5. DO NOT PULL/DESTROY ANY MATERNITY RECORDS
6. Check no current year stickers i.e. 2002 onwards

- Trolley Complete
- DO NOT PRINT CRT LABEL
- Record type Health destroyed – HLTH4DEST
  Library to be set as Destroyed records – DESTROYED1
- When trolley is full – create one new record on CRT regardless of multiple volumes
- Tick list to show records found

- Records transferred to Magnum box
- Sign & Date template and add to box lid when full
- Transfer to the appropriate storage area
- Supervisors to spot check when programme is ongoing and complete.

- Add in secondary field on PMI screen stating month & year patient re attended (DO NOT DELETE HEALTH RECORDS DESTROYED COMMENT)
- Create on CRT Health Record Main – HLTH1MAIN
- If patient represent after records destroyed use existing PMI DO NOT REGISTER

Site Manager to arrange for Magnum to collect and destroy requesting certificates

Printed copies valid only if separately controlled