Sherwood Forest Hospitals
NHS Foundation Trust

RETENTION AND DESTRUCTION PROCEDURE

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Scope/ Target Audience: (delete as applicable / describe)	**Trustwide**

Evidence Base/ References:	Legal: • Data Protection Act 2018 • UK General Data Protection Regulation • Common law duty of confidentiality • Freedom of Information Act 2000 • Public Records Act 1958 • The key principles outlined within the policy in relation to disposal of records after scanning arise from the Civil Evidence Act 1995 and are supported in respect of criminal prosecutions by the Policy and Criminal Evidence Act 1984.

Lead Division:	Corporate
Lead Specialty:	Information Governance
Lead Author:	Information Governance Manager
Sponsor:	Director of Corporate Affairs

	Name the documents here or record not applicable
Associated Policy	Retention and Destruction Policy
Associated Guideline(s)	
Associated Pathway(s)	

Associated Standard Operating Procedure(s)	
Other associated documents e.g. documentation/ forms	Records Management Code of Practice 2021

Consultation Undertaken:	Information Governance Working Group Information Governance Committee

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CONTENTS

1 INTRODUCTION/ BACKGROUND

All NHS records are classified as 'public records' under the Public records Act 1958. Records of NHS organisations are public records in accordance with Schedule 1 of the Act. This means that employees are responsible for any records that they create or use in the course of their duties. This includes records controlled by NHS organisations under contractual or other joint arrangements, or as inherited legacy records of defunct NHS organisations. The Act applies regardless of the format of the records.

The Freedom of Information Act (FOIA) governs access to and management of non-personal public records. The FOIA was designed to create transparency in government and allow any citizen to know about the provision of public services through the right to submit a request for information. This right is only as good as the ability of those organisations to supply information through good records management programmes.

Section 47 of FOIA places a duty on the Information Commissioner to promote the following of good practice by public authorities and the observance by them, of FOIA and codes of practice

The UK GDPR is the principal legislation governing how records, information and personal data are managed. It sets in law how personal and special categories of information may be processed. The Data Protection Act 2018 principles are also relevant to the management of records. Under the UK GDPR, organisations may be required to undertake Data Protection Impact Assessments (DPIA) as set out in Section 3 of this Records Management Code. The UK GDPR also introduces a principle of accountability. The Information Commissioner's Office (ICO) Accountability Framework can support organisations with their obligations. Good records management will help organisations to demonstrate compliance with this principle.

Regulation 17 under the Health and Social Care Act 2008 requires that health and care providers must securely maintain accurate, complete and detailed records for patients or service users, employment of staff and overall management.

Other legislation requires information to be held as proof of an activity against the eventuality of a claim. Examples of legislation include the Limitation Act 1980 or the Consumer Protection Act 1987. The Limitation Act sets out the length of time you can bring a legal case after an event and sets it at six years.

All NHS records are public records under the terms of the Public Records Act 1958 sections 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. This is carried out under the overall guidance and supervision of the Keeper of Public Records, who is answerable to parliament.

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

Retention and disposal scheduling of records is an important aspect of governance of patient information and resources. Not all patient health records can or should be retained indefinitely. The benefits of effective records management are:

- Protecting business critical records and improving business resilience
- Ensuring information can be found and retrieved quickly and efficiently
- Complying with legal and regulatory requirements
- Reducing risk for litigation, audit and investigations
- Minimising storage requirements and reducing costs.

Related Trust Documents

- Retention and Destruction Policy
- Records Management Code of Practice 2021.

3 ROLES AND RESPONSIBILITIES

Chief Executive

The Chief Executive has overall responsibility for this policy within the Trust. Implementation of, and compliance with this policy is delegated to the Senior Information Risk Owner, Caldicott Guardian, Data Protection Officer, and members of the Information Governance Committee.

Senior Information Risk Owner

The Director of Corporate Affairs is responsible to the Chief Executive for Information Governance and is the designated Senior Information Risk Owner, who takes ownership of the Trust's information risk policy, acts as an advocate for information risk on the Board and provides written advice to the Chief Executive on the content of the Statement of Internal Control in regard to information risk. The Senior Information Risk Owner also reports annually to the Trust Board on Information Governance performance.

Caldicott Guardian

The Medical Director is the 'conscience' of the organisation, providing a focal point for patient confidentiality, information sharing and advising on the options for lawful and ethical processing of information as required.

Data Protection Officer

The Data Protection Officer (DPO) has a duty to ensure the Trust complies with data protection legislation. More specifically the Data Protection Officer (DPO) will monitor compliance with the UK GDPR and Data Protection Act principles and conduct internal audits, particularly in relation to Article 5e):

Personal data shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the UK GDPR in order to safeguard the rights and freedoms of individuals ('storage limitation').

The Data Protection Officer (DPO) is the first point of contact for the Information Commissioner's Office and for patients who have concerns about the retention and disposal of their health records.

We are a public authority and have appointed a Data Protection Officer. The Data Protection Officer reports to the Senior Information Risk Owner and works with the Caldicott Guardian.

The Data Protection Officer is tasked with monitoring compliance with Data Protection legislation, our data protection policies, awareness-raising, training, and audits. Our Data Protection Officer acts as a contact point for the Information Commissioner's Office. When performing their tasks, our Data Protection Officer has due regard to the risk associated with processing operations, and takes into account the nature, scope, context and purposes of processing.

Information Asset Owners (IAOs)
Information Asset Owners (IAOs) and Senior Managers are expected to lead by example by promoting a culture which properly values, protects and uses data.

The responsibility for local records and information lifecycle management is devolved to Information Asset Owners (IAOs) and Service Managers, Heads of Department/Professional leads who have overall responsibility for records and information generated by their activities and specifically that:

- records are appropriately captured and retained in registered systems;
- the management and retention and disposal of records takes place in a timely and secure way within their areas of responsibility and in accordance with this policy;
- their staffs receive training, are aware of the requirements of appropriate Information Governance/Governance policies and apply the correct procedures and controls relevant to their work.

Information Asset Owners (IAOs) are responsible for providing assurance to the Senior Information Risk Owner (SIRO) that information, particularly personal information, is effectively managed within their Directorate/ Department.

Information Asset Administrators (IAAs)
Information Asset Administrators ensure that Information Governance policies and procedures are followed, recognise actual or potential Information Governance security incidents and take steps to mitigate those risks, consult their Information Asset Owners on incident management, and ensure that information asset registers are accurate and up to date.

All Staff
All members of Trust staff (including Medirest and Skanska colleagues) are responsible for any record that they create or use. This responsibility is established at, and defined by, the law. Everyone working for the Trust and for the NHS generally who records, handles, stores or otherwise comes across information has a personal common law duty of confidence.

4 PROCEDURE DETAILS (including Flowcharts)

4.1 Permanent Preservation of Paper and Digital Record Archives in Accordance with the Public Records Acts

4.1.1 It is a duty under the Public Records Act for the Trust to make appropriate arrangements for the selection and permanent preservation of public records within their control. That duty is subject to the provision that records of individual patients will not normally be preserved under the Public Records Act, other than by way of templates. The Trust has a selection process for this procedure.

4.1.2 The Information Governance Committee on behalf of the Trust, will from time to time, propose records that they deem suitable for permanent preservation as required by the Public Records Acts 1958 and 1967 and will recommend and offer them to a Place of Deposit approved by the National Archives who may accept or decline. Nottinghamshire Archives, County House, Castle Meadow Road, Nottingham, NG2 1AG are the current approved repositories for the Trust and its predecessor organisations.

4.1.3 Selection will be performed in consultation with health professionals, and archivists from the local Public Records place of deposit. If records are to be sampled, specialist advice must be sought from the same health professionals and archivists.

4.1.4 Once the Trust has made a selection decision, it is then incumbent upon the Trust to keep those records in its safe custody until such time that they can be transferred to the appointed Place of Deposit.

4.1.5 Potential transfers of digital archive material will need to be discussed with the Records Manager and the Place of Deposit to ensure technical and transfer issues are managed.

4.1.6 Approval must be sought from the Keeper of Public Records to retain records for more than 30 years after a patient's last contact with the Trust.

4.1.7 In light of the latest trends in medical and historical research, it may be appropriate to select some of these records for permanent preservation. Selection should be performed in consultation with health professionals and archivists from an appropriate place of deposit. If records are to be samples, specialist advice should be sought from the same health professionals and archivists. If an NHS Trust has taken on a leading role in the development of specialised treatments, then the patient records relating to these treatments may be especially worthy of permanent preservation. All records that make reference to historical child sexual abuse must be retained for permanent preservation.

4.1.8 If a whole run of patient records is not considered worthy of permanent preservation but nevertheless contains some material of research value, then the option of presenting these records to a local record office and other institutions under S.3(6) of The PRA should be considered. Advice on the presentation procedure may be obtained from the PRO's Archive Inspection Services.

4.1.9 If a whole run of patient records is considered worthy of permanent preservation but there is lack of space in the relevant place of deposit to store these records, contact the Information Governance Team who will advise on the most appropriate option available.

4.1.10 All digital and paper records that are selected for destruction must be recorded on the departments Destruction Log, an example of which can be found in Appendix A. Destruction logs are audited as part of the annual Records Inventory.

4.2 Extended or Permanent Retention of Records - Application Process to Information Governance Committee

4.2.1 Applications for either extended or permanent retention of records require evaluation and approval from the Information Governance Committee. Further advice, including legal advice or that from the Information Governance team will be taken wherever necessary.

4.2.2 Applications must be made to Information Governance Committee using the standard Application/Appraisal Form in Appendix B). The applicant must be able to identify each record concerned by D Number or equivalent if not a health record.

4.2.3 Implementation of this appraisal procedure for paper based records commenced in 2004. Prior to this, Consultants were given an opportunity to submit an application for extended or permanent preservation of records that would otherwise be disposed of under the auspices of the policy. Requests were submitted to the Health Records Management Group at the time for evaluation and approved or declined before policy implementation.

4.2.4 Records identified and agreed for extended or permanent preservation must remain in the safe custody of the Trust until disposal or transfer.

4.2.5 Records agreed for extended preservation may at any time be transferred to another media. e.g. scanned to a digital image.

4.2.6 A register of records approved for extended preservation at the Trust forms Appendix C.

4.2.7 From 2004 onwards the front covers of paper based health records approved for extended retention had to be clearly marked by the departments concerned using specific identification stamps/ stickers. The stickers acted as a visual contra-indication to disposal, this system will be superseded in future by use of appropriate CareFlow EPR PAS Alerts. The Research and Innovation team are responsible for identifying health records of patients involved in studies by applying a visible sticker to the red “alert notification” page in medical records. From 2016 onwards this is also detailed using the appropriate CareFlow EPR PAS alert recording ‘Clinical Research Status’.

4.3 Information Governance Committee Appraisal Procedure

4.3.1 In considering individual applications the Information Governance Committee are obliged to use the following appraisal procedure as advocated by Records Management Code of Practice 2021, the advice of the Health Archives Group and the National Archives:

a) Consult with the relevant health professional body and clearly minute the actions;
b) consider any local clinical need; and
c) assess the value of the records for long-term research purposes/value, in consultation with the local public records office;
d) Note existing precedents (the establishment of a continuity of selection).
e) Consider the historical context of records and the history of the institution (pioneering treatments and examples of excellence) within the context of its service to the local and wider community;
f) Ensure the provisions of the UK GDPR and Data Protection Act 2018 are complied with.

4.3.2 The outcome of an Information Governance Committee evaluation will set out a specific time period for extended preservation, the periods determined can be reviewable (‘extended’ preservation), or can immediately recommend ‘permanent’ preservation.

4.3.3 Information Governance Committee will consider and adopt the use of sampling techniques when it appears reasonable to keep only a percentage of records for particular reference.

4.3.4 That the application of retention and destruction of records procedures are regularly monitored against agreed indicators and action taken to improve standards as necessary.

5 EDUCATION AND TRAINING

5.1 Training

Annual data security awareness level 1 (formally known as Information Governance) training is mandatory for all new starters as part of the induction process. In addition all existing staff must undertake data security awareness level 1 training on an annual basis.

Staff can undertake this either face-to-face[1] or online. Provision is available online (or face to face for staff who do not have routine access to personal data) and includes Data Protection and confidentiality issues.

Data security awareness level 1 session meets the statutory and mandatory training requirements and learning outcomes for Information Governance in the UK Core Skills Training Framework (UK CSTF) as updated in May 2018 to include General Data Protection Regulations (GDPR).

Our Senior Information Risk Owner, Information Asset Owners and Information Asset Administrators must attend regular information risk awareness training which is available from the Information Governance team[2].

5.2 Implementation

A copy of this policy and all related policies and procedures are provided to all staff and patients on the Trust's website[3].

[1] https://sfhcoursebooking.nnotts.nhs.uk/fulldetails.aspx?recid=195 (internal web link)
[2] https://sfhcoursebooking.nnotts.nhs.uk/fulldetails.aspx?recid=457 (internal web link)
[3] https://www.sfh-tr.nhs.uk/about-us/policies-and-procedures/non-clinical-policies-procedures/information-governance/

6 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Audit of paper and digital records	Information Governance Team	Audit	Bi-monthly	Information Governance Committee
Adherence to Information Governance policies and procedures in nominated Division/ Department	360 Assurance	Audit	Annually	Information Governance Committee

7 EQUALITY IMPACT ASSESSMENT (please complete all sections)

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Retention and Destruction Procedure			
New or existing service/policy/procedure: New			
Date of Assessment: 12th November 2020			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	Not applicable	None
Gender:	None	Not applicable	None
Age:	None	Not applicable	None
Religion:	None	Not applicable	None
Disability:	Visual accessibility of this policy	Already in Arial font size 12. Use of technology by end user. This policy can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request	None
Sexuality:	None	Not applicable	None

Pregnancy and Maternity:	None	Not applicable	None
Gender Reassignment:	None	Not applicable	None
Marriage and Civil Partnership:	None	Not applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- Trust guidance for completion of the Equality Impact Assessments

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment: Gina Robinson

Signature:

G. H. Robinson

Date: 10th February 2023

8 APPENDICES

APPENDIX A - RECORDS DESTRUCTION LOG

Description of Record to be Destroyed	Electronic or Paper format	Owner/Department	Person Authorising Destruction	Retention Period	Date of Destruction
Email account for Joe Bloggs	Electronic	NHIS	Service Desk Manager	1 year	02.11.2010
Minutes of Health & Safety Committee	Paper	Human Resources	Assistant Director of HR	2 years	05.11.2010
Where relevant this should include the period that the documents cover – e.g. Supplier invoices for 2011/12					

APPENDIX B - APPLICATION FOR EXTENDED ARCHIVE RETENTION OR PERMANENT PRESERVATION OF RECORDS

Applicants must provide a completed application to the Information Governance Committee which is accompanied by a signature of support of their Clinical Director.

Signature of Divisional Director:	**Date:**
Signature of Applicant:	**Date:**

1. Applicant:	**2. Position Held:**
3. Division:	**4. Date:**
5. Employer:	**6. Quantity of records concerned:**
7. Date range of the records concerned:	
8. Are you/information analysts able to identify the records concerned by providing a list of D numbers? YES/NO	

9. How many of the records relate to deceased patients?

10. Is your application for:

A) ☐ Extended archive preservation of records
B) ☐ Permanent Preservation

11. If you are applying for extended archive preservation of records, how long would you wish them to be retained for?

12. What would be the basis for their use?

A) ☐ Research (i.e. Clinical) Please quote any Ethics Committee approval number and date and start and end dates for research.
B) ☐ Historical (i.e. the history of medicine)

Please explain the basis for use:

13. Please provide a summary of the information contained within records which you would use:

14. What is the local need to continue to consult these particular records:

15. How often do you anticipate that you would need to use them?

16. What value do you consider the records have for long term research and are there any plans to carry out this research in future?

APPENDIX C- RECORDS WITH APPROVED EXTENDED RETENTION

Directorate	Responsible Clinician/Applicant	Date of application	Details of extended preservation
Corporate	Lee Radford	13th November 2020	Work experience/work placements records. To be destroyed after for 7 financial years