Patient Care Record - Retention and Disposal Schedule policy

Introduction

The Patient Care Record retention and disposal schedule has been developed in consideration of the IGA Code of Practice for Health and Social Care 2016, legal and statuary requirements and professional bodies.

This retention and disposal schedule is intended to cover all practice records including those which are generated by the function of delivering patient care. It also covers records that may inform patient care including research data. As we move towards an integrated multi stakeholder care model, it aims to bring understanding and consistency across providers.

General Practitioner Records

The General Practitioner (GP) record, usually held at the General Practice, is the primary record of care and that the majority of other services must inform the GP through a discharge note or a clinical correspondence that the patient has received care.

This record is to be retained for the life of the patient plus at least ten years after death. The GP record transfers with the individual as they change GP throughout their lifetime. Existing guidelines to be considered in managing Health and Care records include:

- BMA good practice guidelines for GP electronic records.[1]
- NHS good practice guidance for handling Health and Social Care.[2]

Records at Contract Change

In the standard NHS contract there is an option to allow the commissioner to direct a transfer of care records to a new provider for continuity of service and this includes third parties and those working under any qualified provider contracts. [3] For further guidance relating to the transfer of records see the IGA Code of Practice.[4]

[1] BMA Good Practice Guidelines for GP Electronic Records, V4 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215680/dh_125350.pdf, last accessed 04 11 2019.
[2] NHS Digital, Codes of Practice for Handling Health and Social Care, https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care, last accessed 04 111/2019.
[3] NHS Standard Contract, https://www.england.nhs.uk/nhs-standard-contract/, last accessed 04 11 2019.
[4] NHS Digital, Codes of Practice for Handling Health and Social Care, https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care, last accessed 04 111/2019.

What is a retention and disposal schedule?

A retention and disposal schedule promotes consistency by ensuring that the same type of record is kept for the same amount of time no matter where the record is held. The schedule

- promotes control over the records captured;
- enables staff to dispose confidently of records which are no longer needed;
- ensures the retention of the minimum volume of records consistent with economy and efficiency.

The retention of unnecessary records consumes staff time, space and equipment. It also incurs liabilities in terms of the need to service information requests made under the General Data Protection Regulations (GDPR), Data Protection Act 2018, the Freedom of Information Act 2000 and the Environmental Information Regulations 2004.

The GDPR/Data Protection Act requires records containing personal data to be kept for no longer than necessary; an organisation could receive penalties from the Information Commissioners Office for retaining unnecessary information if this impacts on the rights and freedoms of individuals. Furthermore, individuals who suffer damage, which includes financial loss, and distress, as a result of a contravention of the Data Protection Principles have the right to receive compensation from the data controller or data processor for the damage suffered.

It may be a personal criminal offence to destroy information requested under either of these Acts; the retention and disposal schedule will help with accountability under this legislation by enabling an organisation to demonstrate that any destruction has been undertaken in line with proper procedures and requirements. Destructions undertaken without a retention and disposal schedule will be open to accusations of improper practice.

The Code of Practice issued by the Information Commissioner under section 46 of the Freedom of Information Act 2000 specifically requires organisations subject to this legislation to have retention schedules for all their records. Although compliance with the Code is not mandatory, it is seen as indicative of whether or not an organisation has complied with the legislation.

How are retention periods decided?

Minimum retention periods may be stated in Acts of Parliament and Statutory Instruments, or recommended in codes of practice and business regulations.

The Patient Care Record - Retention and Disposal Schedule takes into consideration the Information Governance Alliance Records Management Code of Practice for Health and Social Care 2016. This is considered as best practice within the sector and includes a comprehensive Records Retention Schedule (link). Where there are specific requirements from other professional body's these will be incorporated into the schedule.

How is this schedule implemented?

In any dispute it is important that the Practice is able to demonstrate that normal practice was followed- the retention schedule represents normal practice.

In most cases an annual round of disposals is appropriate, with a summary log kept to record the fact of the disposal having taken place. Where duplicates and working papers are held relating to regular events and processes, and no other retention period is specified, these may be kept for one year before disposal.

Each Asset Owner is responsible for ensuring that their department apply the retention periods set out in this schedule, regardless of the format or recordkeeping system used. Records marked for permanent retention should be transferred for permanent preservation and provision of access.

Legal Holds

Where the Practice receives notification that there is an investigation or inquiry, we are instructed to ensure that no records in connection with these circumstances are destroyed. This applies to records that would no longer be retained according to the retention Schedule.

Legal holds are also placed on records subject to a Subject Access Request (DPA 2018), Freedom of Information request (FoI Act 2002) or Environmental Information Request (EiR 2004).

The Practice advises staff that legal holds have been received for records shown in the table below.

Start Date	End date	Inquiry/Investigation description	Records affected
2016	On-going	Independent inquiry into Child Sexual Abuse (IICA, chaired by Hon. Dame Lowell Goddard	Includes records and any instances of allegations or investigations or any records where abuse has or may have occurred. Full details can be found at www.iicsa.or.uk
Letter giving notice dated 21 March 2019	On-going	Public inquiry into infected blood and blood products (set up 02 July 2018) chaired by Sir Brian Langstaff	includes, but is not limited to, the following types of material: individual patient medical records, reports, reviews, briefings, minutes; notes and correspondence however held (paper, electronic, microfiche, audio, video and any other means), which is potentially relevant to the Inquiry's Terms of Reference and List of Issues which can be found at https://www.infectedbloodinquiry.org.uk/terms-reference