BASHH Guidance on the Retention and Disposal of Clinical records

Introduction:

In July 2016 a new document was issued by the Information Governance Alliance (IGA) entitled "Records Management Code of Practice for Health and Social Care 2016" (from this point onwards referred to as the Code).

It can be accessed at: http://systems.hscic.gov.uk/infogov/iga/rmcop16718.pdf

Although not specific to sexual health services the Code addresses the key points covered in previous BASHH guidance on the retention and disposal of records. These are copied below for your easy reference but it should be noted that standards and practice covered by the Code will change over time and so the hyperlink above will ensure that the most up to date guidance is accessed.

The Code covers a wide range of data relevant to patient care including: duty rotas, recorded conversations with patients, patient information leaflets, research records, emails, cloud based storage, scanned records, websites; that may be relevant within sexual health but are outside the remit of this summary.

Importantly and relevant for many sexual health services is a table of scenarios about what to do with respect to clinical records when services change to a different provider.

Retention of records

The following is an excerpt from a table summarising duration of retention of records.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM) – see below for advice on long-term conditions, EPR and children	Discharge or patient last seen	8 or 10 years (see Notes)	Review and if no longer needed destroy	Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction taking into account any serious incident retentions. If this is a record of a child, treat as a child record as below.

S Brady 2016

Children's records including midwifery, health visiting and school nursing	Discharge or patient last seen	25th or 26th birthday (see Notes)	Review and if no longer needed destroy	Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Electronic Patient Records System (EPR) NB: The IGA is undertaking further work to refine the rules for record retention and to specify requirements for EPR systems	See Notes	See Notes	Destroy	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the Code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
Record of long term illness or an illness that may reoccur e.g. HIV, syphilis	Discharge or patient last seen	30 Years or 8 years after the patient has died	Review and if no longer needed destroy	Necessary for continuity of clinical care. The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life long illness.

Records at Contract Change

Once a contract ends, any service provider still has a liability for the work they have done and as a general rule at any change of contract the records must be retained until the time period for liability has expired.

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. This will usually be to ensure the continuity of service provision upon termination of the contract. It is also the case that after the contract period has ended; the previous provider will remain liable for their work. In this instance there may be a need to make the records available for continuity of care or for professional conduct cases.

Where legislation creates or disbands public sector organisations, the legislation will normally specify which organisation holds liability for any action conducted by a former organisation. This may also be a consideration to identify the legal entity which must manage the records.

Where the content of records is confidential, for example care records, it may be necessary to inform the individuals concerned about the change. Where there is little impact upon those receiving care it may be sufficient to use posters and leaflets to inform people about the change, but more significant changes may require individual communications or obtaining explicit consent. Although the conditions of the Data Protection Act may be satisfied in many cases there is still a duty of confidence which requires a patient or client (in some cases) to agree to the transfer.

It is vital to highlight the importance of actively managing records which are stored in offsite storage. This will ensure that the organisation maintains a full inventory of what is held offsite, retention periods are applied to each record, a disposal log is kept, and privacy impact assessments are conducted on the offsite storage providers. Table 2 summarises some possible scenarios and, for each option, patient consent and an information sharing agreement or a contract may be required to share the information.

Table 2 - Records at Contract Change Scenarios

Characteristic of new service provider	Fair processing required	What to transfer?	Sensitive records
NHS provider from same premises and involving the same staff. This may be a merger or regional reconfiguration.	Light- notice on appointment letter explaining that there is a new provider. Local publicity campaign such as signage or posters located on premises.	Entire record or summary of entire caseload.	N/A
Non NHS provider from same premises and involving the same staff. This may be a merger or regional reconfiguration.	Light – notice on appointment letter explaining that there is a new provider. Local publicity campaign involving signage and poster and local communications or advertising.	Copy or summary of entire record of current caseload. Former provider retains the original record.	N/A

NHS provider from different premises but with the same staff.	Light – notice on appointment letter explaining that there is a new provider. Local publicity campaign involving signage and poster and local communications or advertising.	Copy or summary of entire record of current caseload. Former provider retains the original record.	N/A
NHS provider from different premises and different staff.	Moderate – a letter informing patients of the transfer with an opportunity to object or talk to someone about the transfer.	Copy or summary of entire record of current caseload. Orphaned records must be retained by the former provider.	Individual communications may not be possible so consent of current caseload may need to be sought before transfer. It may not be possible to transfer the record without explicit patient consent so in some cases no records will be transferred.
Non NHS provider from different premises but with same staff	Moderate – a letter informing patients of the transfer with an opportunity to object or talk to someone about the transfer.	Copy or summary of entire record of current caseload. Orphaned records must be retained by the former provider.	