Witness Name: Lois Evelyn Howell

Witness number: W4188

Statement No: 1

Exhibits: 2

Dated: 22nd December 2020

**INFECTED BLOOD INQUIRY**

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**Exhibit 1 referred to in the First Witness Statement of Lois Evelyn Howell**

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Portsmouth Hospitals
NHS Trust

# RECORDS RETENTION, DISPOSAL AND DESTRUCTION POLICY

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|---|---|
| Version | 7 |
| Name of responsible (ratifying) committee | Data Protection & Data Quality Committee |
| Date ratified | 04 November 2019 |
| Document Manager (job title) | Head of Information Governance |
| Date issued | 23 December 2019 |
| Review date | 04 November 2021 |
| Electronic location | Management Policies |
| Related Procedural Documents | Clinical Records Management Policy, Non-Clinical Records Management Policy, Records Management Strategy, Freedom of Information Policy |
| Key Words (to aid with searching) | Records, Records Management, Health Records, Non-Clinical Records, Disposal, Destruction, Confidentiality Archiving, Places of Deposit |

**Version Tracking**

| Version | Date Ratified | Brief Summary of Changes | Author |
|---|---|---|---|
| 7 | 04/11/2019 | Changes of Legislation and Committee<br>Addition of Exceptions to Retention and Appendix of commonly required retention periods | E Armour |
| 6 | 13/11/2017 | Renamed from Records Retention and Disposal Policy<br>Updated in line with new guidance from the DH<br>Changes to local shredding and minor word changes | E Armour |
| 5 | 12/11/2014 | Update of training requirements to make reference to the Essential Skills Handbook and e-assessment (section 7) | J Taylor |

## CONTENTS

## QUICK REFERENCE GUIDE

For quick reference the guide below is a summary of the actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy.

The Trust must take steps to prevent the ***ad hoc*** disposal of records and ensure that final disposal of records is in accordance with legislation and national guidance.

All Trust staff, whether clinical or administrative, who create, receive and use records, have responsibility for records management. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy.

The Trust follows the record retention schedules as set out in the Records Management Policy for Health and Social Care (2016)

Appraisal of administrative records should be carried out by a senior manager (clinical or non-clinical) who has an understanding of the operational area to which the record relates.

Appraisal of health records will be undertaken by the Health Records Department Manager (or person with delegated responsibility) with appropriate clinical and management support as required. The storage, retrieval and retention of departmentally held records, i.e. GU Medicine, Eye Dept. and Oncology are the responsibility of the departmental managers.

The destruction of any records must be clearly documented. Logs of records destroyed locally should be kept indefinitely by the responsible department. These logs should include the date of destruction and the type or name of the record destroyed.

Many NHS records contain sensitive and/or confidential information and their destruction must be conducted in a secure manner to ensure there are safeguards against accidental loss or disclosure. The normal destruction method used within the Trust is shredding. The shredding of medical records is to be undertaken by a specialist contractor.

All loose confidential waste should be placed in the allocated confidential waste consoles or confidential waste bags.

The secure destruction of computer media is undertaken / approved by the IT Department. Electronic records should be fully erased from Trust servers and systems.

If a record which is due for destruction is known to be the subject of a request for information, destruction should be delayed. It is a **criminal offence** under the Freedom of Information Act 2000 and the Data Protection Act 2018 to destroy or alter information that has been requested, in an attempt to avoid disclosure.

## 1. INTRODUCTION

Disposal scheduling is an important aspect of establishing and maintaining control of corporate information and record resources. Not all information can be retained indefinitely. The Data Protection Act 2018 and the Freedom of Information Act 2000 have imposed new and more stringent duties on public authorities as regards to robust records management practices. Portsmouth Hospitals NHS Trust (the Trust) must take steps to prevent the ***ad hoc*** disposal of records and ensure that final disposal of records is in accordance with legislation and key Department of Health (DH) guidance, in particular, the Records Management Code of Practice for Health and Social Care (2016).

This is particularly important in the electronic environment where uncontrolled copying of information can very easily take place. However, fully functional electronic records management offers a great deal to make this process more orderly, more automated and more secure and also delivering other substantial business benefits.

## 2. PURPOSE

This policy sets out the principles behind records retention, disposal and destruction so that records are not kept for longer than they are needed nor destroyed before their retention period has elapsed and to ensure compliance with the Department of Health NHS record retention schedules guidance.

## 3. SCOPE

This policy is intended for all staff, clinical and non clinical, who hold records in both paper and electronic format, and can include photographs, videos, CD, Blu-ray and DVD.

The Trust has adopted the Records Management Code of Practice for Health and Social Care (2016) which is the key guidance for staff. However, Trust specific information relating to retention and disposal of records is contained within this policy.

This policy should be read in conjunction with the Trust Clinical Records Management Policy and the Non–Clinical Records Management Policy.

*'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety'*

## 4. DEFINITIONS

**Records:** 'Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business. It includes therefore not only paper files series and digital records management systems but business and information systems and the contents of websites.' (ISO 15489-1:2016)

**Health Record:** defined as that which 'consists of information relating to the physical or mental health or condition of an individual, and has been made by or on behalf of a health professional in connection with the care of that individual.' (DPA 2018)

## 5. DUTIES AND RESPONSIBILITIES

**Chief Executive and Senior Managers:**
The Chief Executive and senior managers are personally accountable for the quality of records management within the Trust and have a duty to make arrangements for the safe-keeping and safe disposal of the records.

**Head of Information Governance:**
The Head of Information Governance is responsible for providing specialist records management advice to the organisation, co-ordinate the implementation and monitor compliance with this policy.

**Chief Information Officer (CIO):**
The CIO is responsible for leading on the corporate records management function with support from the Head of Information Governance.

**Health Records Service Manager:**
The Health Records Department Manager are responsible for co-ordinating the cohesive, efficient and effective storage, retrieval, and disposal of patient health records. The Health Records Department Manager will authorise the destruction of health records in liaison with appropriate staff as required.

**Line Managers:**
Line managers must ensure that their staff are adequately trained in records management and enforce adherence to Trust Records Management policies. Senior clinicians only can authorise destruction of health records with written agreement from the Health Records Department Managers. Destruction should take place primarily within the Health Records Department, however records held at ward level may be destroyed in confidential shredding after liaising with their departmental manager. All records that are to be destroyed must be entered on a destruction log and this log should be kept indefinitely.

**All Trust staff:**
All Trust staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and with any guidance subsequently produced.

## 6. PROCESS

As a general rule, information should only be kept as long as absolutely necessary. This includes deleting:

- Unnecessary duplicates of final documents
- Working copies which are no longer required
- Documents which have no continuing value

In all cases, 'good housekeeping' of paper and electronic filing systems is essential to maintaining long-term viability, removing material which should no longer be kept, consistent with this policy. The Trust is only responsible for the retention of its own original documents. Corporate records that require permanent preservation need to be stored appropriately to preserve their integrity and availability. If scanning to an electronic format, please refer to Non-Clinical Records Management Policy.

### 6.1 Schedules

The Trust follows the record retention schedules as set out in the Records Management Code of Practice for Health and Social Care (2016). The current schedules can be found on the Information Governance intranet page.

In the event that a particular record cannot be identified within these schedules, please contact the Head of Information Governance for further advice.

Revision of disposal schedules will be made by the Department of Health / NHS Digital. The Information Governance Manager will monitor all Department of Health / NHS Digital guidance and inform the Trust of any future changes made to the schedules and update this policy accordingly.

### 6.2 Appraisal of Records

The DH record retention schedules outline the recommended **minimum** retention periods for all types of NHS records. The purpose of the appraisal process is to ensure that the record is examined at the appropriate time to determine whether or not it is worthy of archival preservation, whether it needs to be retained for a longer period as it is still in use, or whether it should be destroyed.

Appraisal of administrative records should be carried out by a senior manager (clinical or non-clinical) who has an understanding of the operational area to which the record relates and in accordance with the appropriate retention schedule as set out in the Records Management Code of Practice for Health and Social Care (2016). Guidance can be sought from the Head of Information Governance as required.

Appraisal of health records will be undertaken by the Health Records Service Managers (or person with delegated responsibility) with appropriate clinical and management support as required. The management of departmentally held records, i.e. GU Medicine Eye Dept., Oncology, is the responsibility of the departmental managers. This applies to both paper and electronic records.

### 6.3 Record of Disposal

Disposal of records does not necessarily mean destruction. This could refer to the transfer of records from one media to another e.g. paper records to CD Rom or on to the Trust's server. It could also refer to the transfer of records from one organisation to another e.g. places of deposit or commercial storage. Agreements with suppliers that can access records shall contain appropriate confidentiality and disposal clauses. When undertaking procurement processes the specification shall contain specific requirements regarding disposal of records.

Under the Public Records Act 1958, NHS records over 20 years old which have been selected for permanent preservation and which are not in current use, must be transferred to a recognised place of deposit. Should such a permanent deposit be required the Head of Information Governance will provide guidance.

Those responsible for storing records must ensure that disposal takes place in accordance with current retention schedules, and that disposals occur promptly and consistently. Regular disposal of records (including electronic records) in accordance with the retention schedule is vital to promote the efficient use of space and resources within the Trust and ensure that information is not retained for longer than is necessary for the purpose for which it was recorded to comply with Data Protection requirements.

### 6.4 Destruction of Records

The destruction of records is an irreversible act. Destruction of records should only take place in accordance with the retention schedules as set out in the Records Management

Code of Practice for Health and Social Care (2016). The destruction of any records must be clearly documented. Logs of records destroyed locally should be kept indefinitely by the responsible department. These logs should include the date of destruction and the type or name of the record destroyed.

A decision for destruction of health records must be made by a senior clinician in conjunction with the Health Records Department Manager. **Destruction of health records must not take place without recorded agreement from the Health Records Service Manager.**

**Records must not be destroyed in contravention of the retention schedule without prior consultation with the Data Protection and Data Quality (DPDQ) Committee or the Head of IG.**

For records not already in the public domain (i.e. published or already accessible records), it is vital that confidentiality is safeguarded at every stage including destruction.

It is a **criminal offence** under the Data Protection Act 2018 and the Freedom of Information Act 2000 to destroy or alter information that has been requested, in an attempt to avoid disclosure.

If a record due for destruction is known to be the subject of a request for information, destruction should be delayed. Once the information request is completed, the record should be retained until the complaint and appeal provisions of the Freedom of Information Act have been exhausted.

The destruction of records is an irreversible act. Many NHS records contain sensitive and / or confidential information and their destruction must be conducted in a secure manner to ensure there are safeguards against accidental loss or disclosure.

The normal destruction method used within the Trust for confidential / sensitive paper records is shredding. All loose confidential waste should be placed in the allocated confidential waste consoles or confidential waste sacks. Non-confidential waste can be placed in the recycle bins.

Agreements with suppliers that can access records shall contain appropriate confidentiality and destruction clauses. When undertaking procurement processes the specification shall contain specific requirements regarding destruction of records

The secure destruction of computer media is undertaken by individual Departments (CD, Blue-ray and DVD) once the decision for destruction has been taken These types of media can be placed in confidential shredding. The IT Department is responsible for the eraser of electronic records from Trust servers and systems and the secure destruction of computer hardware (hard drives, laptops, tablets, printers and smartphones). In accordance with the IT Security Policy and associated IT guidelines, the secure destruction of computer media is undertaken / approved by the IT Department and conforms to NHS standards. At end of life; all IT equipment shall be returned to the IT Department for erasure of data and secure disposal or; the process and standards of destruction for computer media being returned to third party suppliers shall be approved with the IT Department. If assistance is required the IT Helpdesk should be contacted. Standard mobile phone destruction is handled by the Trust's current PFI provider.

Medical Records, x-rays and plaster moulds are destroyed under contract with a specialist contractor. A record of disposal decisions must be kept for reference. Please liaise with the South of England Procurement Services (SoEPS) and not with contractors independently. This will ensure that appropriate agreements are put in place and the

agreements shall include the NHS Standard terms and conditions and appropriate confidentiality clauses. The purchase and use of a contractor shall meet the Trust's strategic direction and standards and shall be supported by a Data Protection Impact Assessment.

A record of disposal decisions must be kept for reference.

### 6.5 Exceptions to the Retention schedule.

On occasion records may be kept beyond the recommended retention period. Usually this is related to a public or parliamentary inquiry. Previous and ongoing inquiries have included:

- Child Sexual Abuse Inquiry
- Infected Blood Inquiry
- Gosport War Memorial Inquiry

## 7. TRAINING REQUIREMENTS

The Head of Information Governance has overall responsibility for maintaining training and awareness of Records Management as a part of the Information Governance Training content.

Information Governance training is mandatory and all new starters must receive IG training as part of their corporate induction.

All staff members are required to undertake accredited Information Governance training as appropriate to their role. The preferred method is through the Trust's Essential Skills Handbook (ESH) and associated e-assessment in the Electronic Staff Records (ESR).

Information Governance training must be completed on an annual basis.

## 8. REFERENCES AND ASSOCIATED DOCUMENTATION

Records Management Code of Practice for Health and Social Care (2016)
Public Records Act 1958
Freedom of Information Act 2000
The Data Protection Act 2018
The National Archives' Records Management: Standards and Guidance

The General Data Protection Regulations 2016

**Policies**
Confidentiality and Data Protection Policy

Clinical Records Management Policy

Non-Clinical Records Management Policy

Freedom of Information Policy

*An Organisation-Wide Policy for the Development and Management of Procedural Documents:* NHSLA, May 2007. www.nhsla.com/Publications/

## 9. EQUALITY IMPACT STATEMENT

Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

*All policies must include this standard equality impact statement. However, when sending for ratification and publication, this must be accompanied by the full equality screening assessment tool. The assessment tool can be found on the Trust Intranet -> Policies -> Policy Documentation*

Our values are the core of what Portsmouth Hospitals NHS Trust is and what we cherish. They are beliefs that manifest in the behaviours our employees display in the workplace.
Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.
We are committed to promoting a culture founded on these values which form the 'heart' of our Trust:

***Working together*** for patients
***Working together*** with compassion
***Working together*** as one team
***Working together*** always improving

This policy should be read and implemented with the Trust Values in mind at all times.

## 10. MONITORING COMPLIANCE WITH PROCEDURAL DOCUMENTS

This document will be monitored to ensure it is effective and to assurance compliance.

| Minimum requirement to be monitored | Lead | Tool | Frequency of Report of Compliance | Reporting arrangements | Lead(s) for acting on Recommendations |
|---|---|---|---|---|---|
| ▪ The Information Asset Register is to be maintained by each CSC/department in line with requirements of the IG Toolkit, and which provides an indication on records management, storage, and disposal and destruction issues.<br>▪ Ongoing assessment of volume of records and available capacity within the Health Records Library. Details are reported bi-annually to the IGSG by the Health Records Service Manager. | IG Manager<br>Health Records Service Manager | DSP Toolkit<br>Reports to the Information Governance Steering Group | Yearly<br>Twice Yearly | Head of Information Governance reports to the DPDQ Committee<br>Health Records Service Manager bi-annual reports to the DPDQ Committee | Head of Information Governance Health Records Service Manager |

## APPENDIX 1: Commonly requested retention periods

| Record Type | Retention Start | Retention Period | Notes |
|---|---|---|---|
| Adult health records | Discharge or patient last seen | 8 years | |
| Children's records | Discharge or patient last seen | 25th or 26th Birthday | Retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday |
| Deceased patient's records | Date of death | 8 years | |
| Donor records | Transplant date | 30 years | |
| Joint replacement | Replacement surgery date | 10 years | |
| Obstetric records, maternity records and antenatal and post natal records | Discharge or patient last seen | 25 years | |
| Cancer / Oncology | Diagnosis | 30 years or 8 years after the patient dies | |
| Medical records of patient with Creutzfeldt-Jakob disease (CJD) | Diagnosis | 30 years or 8 years after the patient dies | |
| Clinical Diaries | End of year to which they relate | 2 years | If diary contains clinical activity not transferred to main patient file – then diary must be kept for 8 years. |
| Duty Roster | Close of financial year | 6 years | |
| Complaints | Closure of incident | 10 years | Not to be kept with or in the patient file |

| | | | |
|---|---|---|---|
| Patient Information Leaflets | End of use | 6 years | Review and consider transfer to a Place of Deposit |

This list is not exhaustive and the full guidance should be consulted. If you have any questions, please contact the Head of Information Governance.

## EQUALITY IMPACT SCREENING TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval for service and policy changes/amendments.

**Stage 1 - Screening**

| | | | |
|---|---|---|---|
| **Title of Procedural Document:** Records Retention, Disposal and Destruction Policy | | | |
| **Date of assessment** | 21.10.2019 | **Responsible Department** | DPDQ |
| **Name of person completing assessment** | Emile Armour | **Job Title** | Head of Information Governance |

**Does the policy/function affect one group less or more favourably than another on the basis of :**

| | Yes/No | Comments |
|---|---|---|
| • Age | NO | |
| • Disability<br>Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia | NO | |
| • Ethnic Origin (including gypsies and travellers) | NO | |
| • Gender reassignment | NO | |
| • Pregnancy or Maternity | NO | |
| • Race | NO | |
| • Sex | NO | |
| • Religion and Belief | NO | |
| • Sexual Orientation | NO | |
| **If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2** | | |
| More Information can be found be following the link below<br><br>www.legislation.gov.uk/ukpga/2010/15/contents | | |

**Stage 2 – Full Impact Assessment**

| What is the impact | Level of Impact | Mitigating Actions (what needs to be done to minimise / remove the impact) | Responsible Officer |
|---|---|---|---|
| | | | |

**Monitoring of Actions**

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level

| | |
|---|---|
| Specialty Procedural Document: | Specialty Governance Committee |
| Clinical Service Centre Procedural Document: | Clinical Service Centre Governance Committee |
| Corporate Procedural Document: | Relevant Corporate Committee |

All actions will be further monitored as part of reporting schedule to the Equality and Diversity Committee