Records Retention Policy – including Record Keeping and Retrieval, Archive & Destruction

JENNER HOUSE SURGERY

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Introduction

The purpose of this policy and protocol is to actively encourage and support the Practice and process of excellent record keeping, both in its clinical and non-clinical environments.

Good record keeping is essential in every aspect of the Practice function.

In the clinical setting, it helps protect the welfare of patients (especially vulnerable adults and children) and promotes best-practice from each healthcare practitioner.

Within the non-clinical setting, it is essential in making sure the Practice adopts the highest business standards, and maintains a professional approach and appearance. It is also invaluable in ensuring the smooth-running of the Practice on a day-to-day basis.

In both environments there are a number of legal responsibilities which must be adhered to, particularly in relation to length of time for keeping records.

Practice Statement of Intent

It is the intent of Jenner House Surgery that the highest standards of record keeping will be upheld within the Practice at all times, and that all legal requirements with regard to record retention time-periods and manner of storage are adhered to. This must be able to be proven by way of audit at any given time.

What is a Record?

A record is an account of each activity performed by the Practice. It can be stored in either a printed or electronic format. It provides a complete history of the Practice's actions over an identified time-period.

Types of Records Used

The following record types are kept at the Practice:

- Health records;
- X-rays and scans;
- Photographs, slides and other images;
- Microfilm;
- Server and PC hard drives
- DVDs, CD-ROMs, USBs;
- Administrative and accounting records;

- Diaries;
- E-mails and text messages.

Policy

Responsibility

- Because records are made by every staff member at the Practice, each has his / her own responsibility for ensuring these are relevant, accurate, up-to-date, and stored in the correct manner.
- Staff must log in under their own name and password.
- Information will be recorded under the correct patient on the correct date with appropriate codes.
- Staff have a responsibility to report or correct any errors found when adding new information.

Information Quality Assurance

Practice staff will receive regular training updates with regard to records management and information quality. This includes all aspects of record creation, use and maintenance, covering the following points:

- What information should be recorded and in what manner;
- Why this is being done;
- Ensure information from patients or carers is cross-referenced with other available records to ensure accuracy;
- How to identify and correct errors, and report those errors found;
- What records are being used for (this will help them understand which are the most important aspects of the information they are recording and ensure they are included);
- How information should be updated and how information from other sources can be included.

Record Keeping

Effective and accurate record keeping is made as a direct result of knowledge of the type of records held at the Practice, where they are stored, and their relationship to Practice function.

All record keeping systems will contain descriptive and / or technical documentation to enable efficient operation of the system and ensure that records are easily understood.

Systems, whether electronic or printed format, will include simple rule-sets for referencing, cross-referencing, indexing and, where necessary, protective marking.

Record Maintenance

The movement and location of records will be controlled to ensure that a record can be easily retrieved at any time, that any outstanding actions can be dealt with, and that there is an auditable trail of record transactions.

Storage areas for current records should be clean and tidy; the layout of which should be designed to help prevent damage to the records and should provide a safe working environment for Practice staff.

For electronic records; maintenance in terms of back-up and planned migration to alternative platforms are designed and scheduled in a manner that ensures continued access to readable information.

Equipment used to store current records on all types of media provides storage that is safe and secure from unauthorised access and which meets health, safety and fire regulations. Additionally, the equipment also allows maximum accessibility of all records, commensurate with their frequency of use.

Non-current records are placed in a designated office without patient access, bearing in mind the ongoing need to preserve important information and keep it confidential and secure.

A business continuity plan is in place to provide protection for all types of records that are vital to the continued functioning of the Practice.

Expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations rests with the Practice Manager with the support of the Health and Safety Lead, who is the person with overall responsibility for record keeping and their advice should be sought on these matters.

General Record Keeping Standards
The Practice's policy of good record keeping aims to deliver the following standards of patient care and business professionalism:

- Supports the highest standards of clinical care;
- Supports greater continuity of care;
- Provides better communication and dissemination of information between clinical and non-clinical teams;
- Provides an accurate account of treatments given, and promotes best care planning and delivery of services;
- Enables early warning of potential problems (e.g. changes in the patient's condition);
- Supports evidence-based clinical practices;
- Complies with legal requirements (e.g. Data Protection Act and Access to Health Records Act);
- Assists with the audit process, both in a clinical and non-clinical setting;
- Supports improvement and advancement in clinical practices and effectiveness of these;
- Promotes patient choice and decision-making with regard to their treatment and the services on offer;
- Provides evidence for the basis of legal or professional proceedings;
- Supports efficiency and accuracy when dealing with suppliers and other outside bodies;
- Establishes a clear and effective accounting procedure.

Record Keeping within Consultations Protocol
All clinical staff must adhere to the Practice's record keeping within consultations protocol.

The following information should be routinely recorded to ensure completeness in the patient record (you may wish to include Read Codes for various entries so that you are able to undertake searches at a later date for audit purposes - templates within the clinical system can be devised and used to ensure consistency and accuracy).

- Discussion that takes place within the consultation;
- The reason the patient has attended;
- Clinician's findings (including conditions that were looked for and not found);
- Proposed treatment plan and whether the patient agrees with this;
- Any medication prescribed and how they can report side effects;
- Any follow up plans;
- Information given on lifestyle changes and health promotion and whether the patient refuses to access this (e.g. smoking cessation clinic, weight management);
- Use clinical templates to record information where possible as this ensures accurate consistent coding.
- Any refusal to accept surgical intervention once referred (see referral protocol);

- Any discussions on choice;
- Any discussions regarding particular needs of the patient.

Where the consultation takes place at the patient's home, the clinician must ensure notes of the consultation are transferred to the patient record as soon as possible.

If the notes are factually incorrect, the Practice or Assistant Practice Manager should be notified and the entry corrected. Any alterations to the clinical record will show the reason for the change.

Avoid unnecessary comments (patients have the right to access their records and a flippant remark might be difficult to explain). It is important to note with the introduction of the General Data Protection Regulations 2018, patients can request full access to their medical record at no cost.

All new diagnoses should be recorded and any consultations that take place regarding the diagnosis should be recorded under that heading.

Any injections given should be recorded together with the name and batch number of the vaccine given and the site (e.g. left deltoid, right buttock). Patients must be advised on possible reactions or side-effects and what they should do if they experience any.

Where minor surgery or coil-fits are undertaken, ensure disposable instruments are used.

Record batch numbers where applicable. Patients must be advised on possible reactions or side-effects and what they should do if they experience any. Detail any follow-up requirements (e.g. check-up or stitch removal).

Archive & retrieval
A patients electronic record will be archived following a patient death, or if that patient re-registered at another surgery. Within the clinical system, the notes will become inactive. The functionality is there to access the medical records of a de-registered patient, however there must be good reason for doing this. It is an audited activity and staff members will be prompted on attempting to access to provide a reason for that access.

Patient paper notes will be forwarded to the patient's new GP practice if they have re-registered or to Primary Care Support England if they are deceased.

Other paper records, not associated directly with a patient's medical record e.g. archived insurance paperwork will be categorised, labelled and placed into an envelope for archiving. Records are maintained in a designated area in the Practice Managers office.

Paperwork associated with business matters will be categorised, labelled and placed into an envelope for archiving. Records are maintained in a designated area in the Practice Managers office.

Destruction
All records will be maintained as per the records retention schedule below, guided by the Information Commissioners Office Retention Schedule (August 2018).

Destruction of records is conducted by the Practices designated shredding provider: Shred It. All containers are locked, and only should be emptied by the Shred It staff member collecting the paper for destruction, or in exceptional circumstances supervised by the Practice Manager and Assistant Practice Manager.

Records Retention Schedule

Record	Retention period (years)	Comments
Accident reports	10	Where litigation has been commenced, keep as advised by legal representatives.
Accounts - Annual (Final - one set only)	Permanent	CQC required period is 30 years
Accounts Minor records (pass books; paying-in slips; cheques counterfoils; cancelled/discharged cheques; accounts of petty cash expenditure; travelling and subsistence accounts; minor vouchers; duplicate receipt books and income records.	6	
Bills, receipts and cleared cheques	6	
Buildings and engineering works, Inclusive of major projects abandoned or deferred - town and country planning matters and all formal contract documents (e.g. Executed agreements, conditions of contract, specifications, "as built" record drawings and documents on the appointment and conditions of engagement of private buildings and engineering consultants.		The general principle to be followed in regard to these records is that they should be preserved for the life of the buildings and installations to which they refer.
Building records (mortgage, transfers, disposal etc)	Permanent	
Buildings and Premises – general maintenance records	3 years	
Cash Books	6	The Limitation Act, 1980
CCTV Images	31 days	Unless retention otherwise justified
Clinical Audit records	5	
Clinical System patient records	Permanent	Retain indefinitely for the foreseeable future
Complaints	10	Where litigations has been commenced, keep as

		advised by legal representatives
Computerised records	The recommended minimum retention periods apply to both paper and computerised records, though extra care needs to be taken to prevent corruption or deterioration of the data. Re-recording / migration of data will also need to be considered as equipment and software become obsolete. For guidance, see the Public Record Office guidance, Management and Appraisal of Electronic Records (1998) – see link below	
Contracts	6	The Limitation Act, 1980
Death Certificates and death Records	2	
Diaries (office)	1	
Employment Records – see Personnel files and Payroll records below		
Equipment maintenance records	3	
Electrical Testing records	3	
Fire safety Records	5	
Freedom of Information Act Requests	3	
Fridge Temperature Records	1	
Funding data	6	
Insurance certificates	40	
Job advertisements	1	
Job applications and descriptions (following termination of employment)	3	
Medical gas storage, transport and safety	3	
Minutes of Meetings	1	
Out of Hours Records	3	Where these are held as part of the clinical system the longer period of retention relating to clinical system records applies.
Paper Patient Records	20	20 years after last recording. 10 years after death. For patients treated under the Mental Health Act retain for 30 years after last recording.

Payroll / PAYE records	10	For superannuation purposes authorities may wish to retain such records until the subject reaches benefit age. Retain for 10 years after termination of employment
Personnel files (e.g. Personal files, letters of appointment, contracts references & related correspondence)	6	For current staff: See list in **Appendix B** For former staff, keep for 6 years after subject of file leaves service, or until subject's 70th birthday, whichever is the later. Only the summary needs to be kept to age 70; remainder of file can be destroyed 6 years after subject leaves service.
Policies and Procedures (general operating policies)	3 years	Current version and all previous versions to be retained for a minimum 3 year period. 5 years recommended
Purchasing orders excluding medical devices and medical equipment	18 months	
Purchasing orders - medical devices and medical equipment	11 years	
Risk assessments	3	Retain three years and ensure that subsequent risk assessments are available
Rotas and staff duty rosters	4	4 complete years following the year to which they relate
Significant Event records	3	Including those to be notified to the CQC
Superannuation Forms (SD55)	10	
VAT Records	6	Complete years following the end of a VAT period
Water Safety records	5	

NHS Digital on records retention and handling patient information: https://digital.nhs.uk/codes-of-practice-handling-information

The Medical Protection Society recommend that any records not specifically mentioned elsewhere should be retained for 10 years after conclusion of treatment, the patient's death or after the patient has permanently left the country.

Government guidance on employee data: https://www.gov.uk/data-protection-your-business

Appendix A

For countries other than England and Scotland the guidelines are unclear.
The following resources may be of assistance to those practices unable to trace local guidelines.

Wales

Guidance document is accessed via the NHS Wales website.
http://www.wales.nhs.uk/sites3/page.cfm?orgid=950&pid=51799

Scotland

REVISED RECORDS MANAGEMENT: NHS CODE OF PRACTICE NOW AVAILABLE (Scotland) The Scottish Government has published a revised Records Management: NHS Code of Practice. The code is intended to be a guide to the required standards of practice in the management of records for those who work within, or under contract, to NHS organisations in Scotland.
http://www.scotland.gov.uk/Publications/2010/04/20142935/0

Northern Ireland

DoH NI website but excludes GP records.

https://www.health-ni.gov.uk/topics/good-management-good-records

Appendix B

Employment Records Retention Periods

National minimum wage
Record: Records sufficient to establish that every worker is being, or has been, remunerated at a rate at least equal to the national minimum wage. **Retention period:** Three years from the day the pay reference period immediately following that to which the records relate ends. **Form of record:** Records must be in a form that enables the information kept about a worker in respect of a pay reference period to be produced in a single document. **Legislation:** National Minimum Wage Regulations 2015 (SI 2015/621), reg.59.
Working time restrictions
Record: Records that are adequate to show that the limits on weekly working time, daily and weekly working time for young workers, and night work (including night work involving special hazards or heavy physical or mental strain); the restriction on employing young workers during the "restricted period"; and the requirement to give every worker an opportunity of a free health assessment before he or she is transferred from day work to night work and at regular intervals thereafter are being met. **Retention period:** Two years from the date on which the records were made. **Form of record:** None prescribed. **Legislation:** Working Time Regulations 1998 (SI 1998/1833), reg.9.
Incapacity for work and statutory sick pay

Record:

- all sickness periods lasting at least four days;
- statutory sick pay (SSP) payments; and
- weeks SSP not paid and why.

Retention period: Three years after the end of the tax year in which the sickness periods occurred and SSP payments were made.

Form of record: None prescribed. An approved form is available from HM Revenue and Customs (SSP2 SSP record sheet) (on the HMRC website).

Legislation: Not a statutory requirement, but HM Revenue and Customs may check that employers are paying SSP correctly, and has the power to impose penalties for a failure to keep records.

Absence during pregnancy and statutory maternity pay

Record:

- the date of an employee's first day of absence from work wholly or partly because of pregnancy or confinement as notified by her and, if different, the date of the first day when such absence commenced;
- the weeks in that tax year in which statutory maternity pay (SMP) was paid to that employee and the amount paid in each week;
- any week in that tax year within the employee's maternity pay period for which no payment of SMP was made (and why); and
- any medical certificate or other evidence relating to the employee's expected week of confinement or, as appropriate, her confinement.

Retention period: Three years after the end of the tax year in which the employee's maternity pay period ended.

Form of record: None prescribed. An approved form is available from HM Revenue and Customs (SMP2 SMP record sheet) (on the

HMRC website).

Legislation: Statutory Maternity Pay (General) Regulations 1986 (SI 1986/1960), reg.26.

Note: Where an employer returns a medical certificate to an employee for the purpose of enabling her to make a claim for benefit, it will be sufficient for a copy of that certificate to be retained.

An employer shall not retain any certificate of birth provided as evidence of confinement by a woman who is or was an employee, but shall retain a record of the date of birth.

Statutory paternity pay, statutory shared parental pay and statutory adoption pay

Record:

the date the paternity pay period, shared parental pay period or adoption pay period began;

the evidence provided by the employee in support of his or her entitlement to statutory paternity pay (SPP), statutory shared parental pay (ShPP) or statutory adoption pay (SAP) (in compliance with the Statutory Paternity Pay and Statutory Adoption Pay (General) Regulations 2002 (SI 2002/2822), regs.9, 15 and 24, or statutory shared parental pay (ShPP) (in compliance with the Statutory Shared Parental Pay (General) Regulations 2014 (SI 2014/3051) regs.6, 7, 19 and 20);

the weeks in that tax year in which payments of SPP, ShPP or SAP were made and the amount paid in each week; and

any week in that tax year which was within the employee's paternity pay period, shared parental pay period or adoption pay period but for which no payment was made (and why).

Retention period: Three years after the end of the tax year in which payments of SPP, ShPP or SAP were made.

Form of record: None prescribed. Approved forms are available from HM Revenue and Customs SAP2 SAP record sheet, SPP2 SPP record sheet (on the HMRC website).

Legislation: Statutory Paternity Pay and Statutory Adoption Pay (Administration) Regulations 2002 (SI 2002/2820), reg.9 and Statutory

Shared Parental Pay (Administration) Regulations 2014 (SI 2014/2929), reg.9

Accidents at work and work-related illness

Record: Every employer with 10 or more employees must keep readily accessible a means by which an employee may record the particulars of any accident causing personal injury to him or her.

Retention period: Minimum of three years from the date on which the record was made.

Form of record: Form BI 510 (available from the HSE books website) or an equivalent record (written or electronic) which includes the prescribed particulars, as set out in sch.4 to the Regulations.

Legislation: Social Security (Claims and Payments) Regulations 1979 (SI 1979/628), reg.25.

Injuries, fatalities, diseases and dangerous occurrences

Record: Record of any: reportable incident under regs.4-7 of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (SI 2013/1471); reportable diagnosis under regs.8-10 of the Regulations; injury to a person at work resulting from an accident arising out of or in connection with that work, incapacitating him or her for routine work for more than three consecutive days; and other particulars approved by the Health and Safety Executive or the Office of Rail Regulation for demonstrating compliance with the approved manner of reporting under part 1 of sch.1.

Retention period: Minimum of three years from the date on which the record was made.

Form of record: None prescribed. The particulars required to be kept are set out in part 2 of sch.1 to the Regulations. Alternatively, approved forms are available from the incident reporting page on the Health and Safety Executive website, including F2508IE - Report of an injury, F2508DOE - Report of a dangerous occurrence and F2508AE - Report of an occupational disease).

Legislation: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (SI 2013/1471), reg.12.

Risk assessments

Record: Where an employer employs five or more employees, it shall record:

the significant findings of the risk assessment (as prescribed by the Management of Health and Safety at Work Regulations 1999, reg.3(1));

any group of employees identified by the risk assessment as being especially at risk; and

any arrangements for the effective planning, organisation, control, monitoring and review of preventive and protective measures, made in accordance with reg.5(1).

Retention period: No time limit specified.

Form of record: None prescribed. For guidance on carrying out a risk assessment see INDG163 (Five steps to risk assessment) (PDF format, 114K) (on the HSE website).

Legislation: Management of Health and Safety at Work Regulations 1999 (SI 1999/3242), regs.3 (6) and 5.

Note: The employer must review the risk assessment if there is reason to suspect that it is no longer valid or there has been a significant change in the matters to which it relates.

Exposure to specified hazardous substances

Record: Record of health surveillance, containing particulars approved by the Health and Safety Executive (HSE), of persons where appropriate (see the Control of Substances Hazardous to Health Regulations 2002, reg.11 (2)) who are, or are liable to be, exposed to substances hazardous to health.

Retention period: 40 years from the date of the last entry made in it.

Form of record: None prescribed, but must contain the information specified in Control of substances hazardous to health: Approved Code of Practice and guidance (fifth edition) (PDF format, 919K) (on the HSE website).

Legislation: Control of Substances Hazardous to Health Regulations 2002 (SI 2002/2677), reg.11.

Wages and deductions

Record: PAYE records that employers are not otherwise required to send to HM Revenue and Customs under the Income Tax (Pay As You Earn) Regulations 2003. Employers should keep full and accurate payroll records for each employee, including name; address; payslips (or other record showing gross earnings, tax, national insurance contributions and student loan deductions, and net pay); and records used to complete P11Ds. HM Revenue and Customs can ask for evidence of calculations and supporting information.

Retention period: Three years after the end of the income tax year to which the records relate.

Form of record: None prescribed.

Legislation: Income Tax (Pay As You Earn) Regulations 2003 (SI 2003/2682), reg.97.