NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Records Management Policy

Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	7
Responsible Executive Director:	Shane Devlin, Chief Executive
Author and Job Title:	Sarah Carr, Corporate Secretary and Lucy Powell, Corporate Support Officer
Date Approved:	1 July 2022 (as part of the Core Policies approval) 1st February 2024
Approved by:	ICB Board
Date of next review:	February 2026 (Every two years)

Policy Review Checklist

	Yes/ No/NA	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	See Appendix 1
Has the review taken account of latest Guidance/Legislation?	Yes	The policy is compliant with the Freedom of Information Act 2000 and the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (the Data Protection legislation). The policy also aligns to the Records Management Code of Practice 2023.
Has legal advice been sought?	No	Specialist advice has been taken from Information Governance Advisors. Information Governance

	Yes/ No/NA	Supporting information
		is represented on the Corporate Policy Review Group.
Has HR been consulted?	Yes	HR is represented on the Corporate Policy Review Group.
Have training issues been addressed?	Yes	Training is referenced in the policy. The ICB's Information Governance training includes Records Management; this training is mandatory and annual. Training on ICB specific procedures as set out in the appendix will be tailored to relevant staff groups and will be at least annual.
Are there other HR related issues that need to be considered?	No	There are no HR issues raised by the policy
Has the policy been reviewed by Staff Partnership Forum?	N/A	As there are no HR issues the policy has not been reviewed by the Staff Partnership Forum
Are there financial issues and have they been addressed?	No	There are no financial issues. Physical records archive budget is included within corporate costs
What engagement has there been with patients/members of the public in preparing this policy?	N/A	This policy describes a statutory responsibility and there has been no engagement with patients/members of the public beyond that undertaken by government as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies and procedures are recorded in the policy
Has the lead Executive Director approved the policy?	Yes	Shane Devlin, Chief Executive

	Yes/ No/NA	Supporting information
Which Committees have assured the policy?		Corporate Policy Review Group and Audit and Risk Committee. Both provided feedback which has been included.
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with staff, patients and the public?	Yes	The policy will be published on the ICB website and intranet and will be featured in the internal news communication.
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	
Has a DPIA been considered in regards to this policy?	No	No DPIA required
Have Data Protection implications have been considered?	Yes	The Policy is compliant with the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (Data Protection legislation)

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Records Management Policy

1 Introduction

NHS Bristol, North Somerset and South Gloucestershire ICB (BNSSG ICB) is committed to a systematic and planned approach to the management of its records, throughout their life cycle from creation to through to their ultimate disposal. This approach is in line with the "Records Management Code of Practice for Health and Care Records 2023 V5" published by NHS England. The code of practice is a guide to the required standards of practice in the management of records and is relevant to all organisations who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

1.1 BNSSG ICB Values

Adoption of this approach by the organisation and its staff supports the ICB's values including the commitment to do the right thing.

2 Purpose and scope

The purpose of this policy is to provide a framework which enables BNSSG ICB to set out its records management arrangements for both its digital and paper records. This policy ensures that BNSSG ICB is able to comply with the legal and professional obligations set out for records and in particular:

- Public Records Act 1958
- UK GDPR and Data Protection Act 2018
- Access to Health Records 1990
- Freedom of Information Act 2000
- Regulation of Investigatory Powers Act 2000
- Records Management Code of Practice for Health and Care Records 2023 (v5)
- Professional Obligations (GMC, NMC)

Failure to comply with the regulations could result in reputational damage to BNSSG ICB and carries significant financial penalties in line with ICO standards.

This policy applies to all staff, regardless of whether they hold a corporate or clinical role and includes:

- Individuals on the ICB Board and Committees
- Employees including those seconded to BNSSG ICB
- Third parties acting on BNSSG ICB's behalf (including commissioning support and shared services)
- Agency, locum and other temporary staff engaged by BNSSG ICB
- Students, including those on work experience, trainees and apprentices.

3 Duties – legal framework for this policy

The Public Records Act 1958 is the principal legislation relating to public records. This Act outlines the responsibility of employees 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 Freedom of Information Act 2000 governs access to and management of public records. The FOI Act was designed to create transparency and provide the public with the right to access information. This right is only as effective if the organisation practices good record management processes. Records should be managed in line with the code of practice on record keeping under section 46 of the FOI Act.

UK GDPR and The Data Protection Act 2018 are the principal legislations governing how records and information relating to personal data is managed.

The Health and Social Care Act 2012 requires that health and care providers must securely maintain accurate, complete and detailed records for patients or service users and employment of staff.

4 Responsibilities and Accountabilities

The Chief Executive through the Executive Team is accountable for Records Management within BNSSG ICB and reporting any breaches.

The Chief Transformation and Digital Information Officer, who is the Senior Information Risk Officer (SIRO) for the ICB, has the lead responsibility for Records Management and for ensuring this policy is implemented and becomes an active document within BNSSG ICB.

Executive Directors are responsible for ensuring that this policy is implemented in their individual directorates. They will nominate Information Asset

Owners/Information Asset Administrators who will liaise with the Corporate Secretary or their nominated deputy, regarding the management of records in the directorates.

The Corporate Secretary has operational responsibility for the Records Management Policy and is responsible for the overall development and maintenance of the Records Management Framework and for ensuring this policy complies with legal and regulatory edicts. The Corporate Secretary is responsible for developing and supporting a culture of high quality records management practice across BNSSG ICB to deliver associated organisational benefits. The Corporate Secretary is also responsible for off site physical storage arrangements and associated contract management. Reports on off site record storage will be shared with the Information Governance Group routinely.

BNSSG ICB has a service level agreement with the Information Governance team, part of NHS South, Central and West Commissioning Support Unit, which has responsibility for ensuring that national guidelines are communicated, implemented and local guidelines and protocols on the handling and management of confidential personal data are in place. This will involve joint working with SCW IT and the servers/cloud where many records are stored.

The Corporate Support Officer provides operational management support for records management, arrangements for archiving and the maintenance of the destruction and retention schedule.

Information Asset Owners are responsible for ensuring the asset they 'own' is managed in accordance with this policy, and also for maintaining adequate records within the context, both legal and regulatory, of the business area the asset operates. In doing this they will be responsible for:

- Reviewing/adopting tracking and registration systems for appropriate records
- Ensuring that clinical records are bound and stored so that loss of documents is minimised
- Ensuring that semi-current records are archived in appropriate, secure areas
- Ensuring that there is a mechanism for identifying records which must be kept for permanent preservation.
- Ensuring a contingency or business continuity plan is in place to provide protection for records

Information Asset Administrators are responsible for assisting the Information Asset Owners in the management of the records that they 'own'.

Line Managers are responsible for ensuring that staff undertake any required training and are aware of requirements associated with Records Management processes. They are also responsible for ensuring that leavers undertake the necessary archiving and handover of records before leaving the ICB/team.

The BNSSG ICB Caldicott Guardian is responsible for approving and ensuring that national and local guidelines and protocols on the handling and management of confidential personal data are in place.

All staff are responsible for keeping a record of any significant business transaction conducted as part of their duties for BNSSG ICB. The record should be saved appropriately, a retention period assigned and access controls applied if necessary. Staff also have a responsibility to contribute to the upkeep of Information Asset Registers and Data Flow Map.

The Freedom of Information Act makes it an offence to alter, deface, block, erase, destroy or conceal any record held by BNSSG ICB, with the intention of preventing disclosure to all or part of the information that an applicant is entitled to. Penalties can be imposed on both BNSSG ICB and employees for non-compliance with the Freedom of Information Act and Data Protection Legislation.

Staff must only access records that are appropriate to their role and must not access records which would create a conflict of interest.

Staff are expected to manage records about individuals in accordance with this policy irrespective of their race, disability, gender, age, sexual orientation, religion or belief, or socio-economic status.

Individuals leaving BNSSG ICB are responsible for ensuring that the necessary arrangements have been undertaken in relation to saving key documents sensibly and ensuring that emails and attachments have been saved or deleted as required and in accordance with the retention schedule.

Where BNSSG ICB has contracts in place with other organisations it will, through the NHS Standard Contract, ensure a requirement for correct governance processes to be in place for the management and disposal of records.

5 Definitions/explanations of terms used

A record is defined as ‘Information created, received, and maintained as evidence as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business’. This Policy covers both paper and digital records.

The Data Protection Act 2018 defines a health record as a record which:

- Consists of data concerning health
- Has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates

All records provide evidence of the activities of BNSSG ICB’s functions and policies. Records have strict compliance requirements regarding their retention, access and

destruction. A record can be in various formats including email, paper, digital, social media, videos and telephone messages.

Records are created to provide information about what happened, what was decided, and how to do things. Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management function ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required.

Records management is about controlling records within a framework made up of policies, standard operating procedures, systems, processes and behaviours. Together they ensure that reliable evidence of actions and decisions is kept and remains available for reference and use when needed, and that the organisation benefits from effective management of one of its key assets, its records.

A records retention schedule sets out the classes of records which BNSSG ICB retains and the length of time these are retained before a final disposition action is taken (i.e. destruction or transfer to an archive). It applies to information regardless of its format or the media in which it is created or might be held. All staff members should be familiar with this records retention schedule and apply retention periods to records. The BNSSG ICB retention schedule (Appendix 5) is based on and complies with the Records Management Code of Practice for Health and Social Care 2023 retention schedule.

6 Registration of Records

All information that has a clinical relevance or contains personal data should be logged/registered in accordance with the appropriate record keeping system.

Administrative records are not normally registered. If the category of record merits registration, formal protocols will be issued following decisions made by Executive Directors and/or the Caldicott Guardian/Information Governance team.

Employees are responsible for ensuring that the best practice principles of logging are adhered to:

- The file title must be unique
- The reference identity assigned to each file must be unique
- Both of the above must be relevant to and easily understood by all users
- Details should be recorded both on the file cover and in the register.

If appropriate, a tracking system must be in place. As a minimum it should include

- Patient identifier
- A description of the item e.g. the file title
- The name of the person holding the record
- The date record taken from file
- The name of the person completing the form

Under Data Protection Legislation organisations are required to complete Data Protection Impact Assessments (DPIAs) where there is a new use or change in the use of personal data and there is a potential high risk to privacy. This can include the establishment of a new records management function for those particular records. The ICB Data Protection Officer and SCW CSU IG will be able to provide further advice.

7 Record naming and maintenance

Staff should refrain from naming folders or files with their own name unless the folder or file contains records that are biographical in nature about that individual, for example, personnel records.

Version Control is the management of multiple revisions to the same document. Where records contain personal data, special category data or corporate sensitive information it is a legal requirement that such data is stored securely.

Good record keeping should prevent record duplication. Staff members should ensure team members have not previously created a record prior to initiating a new document and regularly communicate about the correct version and location of saved material.

Good record keeping requires information to be recorded at the same time an event has occurred or as soon as possible afterwards.

Staff should ensure their handwriting is legible when making entries on paper records.

Staff should ensure records are relevant including their opinions about individuals, as the individual has the right to gain access to their records via a Subject Access Request under UK Data Protection Legislation.

Electronic documents and records should be maintained in accordance with this Records Management Policy. The movement and location of paper records should be controlled to ensure that a record can be easily retrieved at any time. This will enable the original record to be traced and located if required and must be held in a shared location. Paper file storage must also be safe from unauthorised access and meet fire regulations.

Information Asset Owners should ensure they have a contingency or business continuity plan to provide protection for records which are vital to the continued functioning of the ICB.

8 Record Access

There are a range of statutory provisions that give individuals the right of access to information created or held by BNSSG ICB. Data Protection Legislation allows individuals to find out what personal data is held about them. The Freedom of Information Act 2000 gives the public the right of access to information held by public authorities. Any requests for information should be sent to the Information Rights Team via the shared inbox: bnssg.foi@nhs.net

Should a request for information be received verbally, this should be recorded in writing and sent to the Information Rights Team for processing. The Information Rights Team will undertake any redactions required prior to release.

9 Record disclosure

There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly a range of provisions that require or permit disclosure. Only certain staff members have the authority, which is dictated by their role, to disclose records. Staff with this authority should make a record of any copies of records they have disclosed, and to whom.

Information requests received outside of business as usual should be sent to the ICB Information Rights team: bnssg.foi@nhs.net who will process the request accordingly.

10 Record retention and destruction

Records should only be destroyed in accordance with the BNSSG ICB Records Retention and Disposal Schedule. It can be a personal criminal offence to destroy requested information under either the Data Protection Act (Section 173) or the Freedom of Information Act (Section 77). BNSSG ICB needs to be able to demonstrate clearly that records destruction has taken place in accordance with proper retention procedures.

The Code of Practice on Records Management, issued under Section 46 of the Freedom of Information Act 2000, requires that records disposal 'is undertaken in accordance with clearly established policies that have been formally adopted'. The BNSSG ICB Records Retention and Disposal Schedule is a key component of the ICB's information compliance and allows a standardised approach to retention and disposal.

The recommended retention periods given on the BNSSG ICB Records Retention and Disposal Schedule apply to the official or master copy of the records. Any duplicates or local copies made for working purposes should be kept for as short a period of time as possible. Duplication should be avoided unless absolutely necessary. It should be clear who is responsible for retaining the master version of a record and copies should be clearly marked as such to avoid confusion.

Some types of records which may be created and kept locally are the responsibility of the local department, but may be found under a different function on the retention schedule: for example where recruitment is carried out by departments, the department shall be responsible for ensuring the disposal of the records relating to unsuccessful candidate, this type of record is listed under Human Resources in the retention schedule.

Records selected for archiving in line with the ICB retention scheme and no longer in regular use by BNSSG ICB should be transferred to the ICB's archive provider institution. When files are no longer current and removed into storage, the details must be entered on the Retention and Disposal of Records Schedule, which is attached at Appendix 3 and kept by the Directorate. A copy should be sent to the Corporate Support Officer who will hold a master copy of the organisation wide schedule.

Preparation of records for storage will be undertaken using the protocol outlined in Appendix 4.

Details of the destruction of these records must be entered on the Retention and Disposal Schedule and a copy will also be kept by the Corporate Support Officer.

If a record due for destruction is known to be the subject of a request for information or potential legal action, destruction should be delayed until disclosure has taken place or, if the organisation has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted or the legal process completed.

11 Electronic Documents

It is important that staff save a copy of any key emails and/or attachments relating to their work in an appropriate folder on the network drive. This allows the ICB to retain a full record of any discussions or decisions that have taken place. An appropriate naming convention should be used, documented and communicated to relevant users of the information asset. As a guide should include – Date in YYYYMMDD format, followed by the project or work name, email topic, and if there are multiple emails with the same date, a (1), (2) etc. to show which comes first.

Individuals leaving BNSSG ICB are responsible for ensuring that the necessary arrangements have been undertaken in relation to saving key documents sensibly

and ensuring that emails and attachments have been saved or deleted as required and in accordance with the retention schedule.

Staff are expected to review their mail archiving systems on a regular basis which will in turn free up inbox space. The ICB will only support the funding of additional inbox space in special circumstances. Where this is granted it should not be relied upon for archiving purposes and does not replace any requirement for staff to save key emails on the network drive. Agreement of extension to inbox space will be subject to need with assurance that archiving responsibilities have properly been fulfilled and may be affected by future IT developments such as N365.

The guidance in this document around retention also applies to electronic documents and guidance around the destruction of electronic records can be found in the SCW CSU ICT Disposal policy.

12 Public Inquiries

Public inquiries rely on records as evidence. Inquiries can require huge amounts of records in a variety of formats. When an inquiry is conducted, the Inquiry Team will outline which records they are interested in reviewing. If the ICB holds the records requested these must be provided. The ICB must consider when Public Inquiries are announced, what type of records may be required and retain these. Contact the team responsible for collating Inquiry records for advice before deleting.

13 Training requirements

The information and responsibilities within this policy will be disseminated to staff by the publication of this policy on the BNSSG ICB website and intranet, and also via training sessions with all members of BNSSG ICB staff through mandatory Information Governance related training that is completed annually.

14 Equality Impact Assessment

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry

15 Implementation and Monitoring Compliance and Effectiveness

An implementation plan has been prepared and is attached at appendix 2. Compliance with this policy will be monitored by the Corporate Governance team through exception reporting together with periodic reviews by Internal Audit and annually through the Data Security and Protection Toolkit.

16 Countering Fraud, Bribery and Corruption

The ICB is committed to reducing fraud in the NHS to a minimum, keeping it at that level and putting funds stolen through fraud back into patient care. Therefore, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

ICB employees should be aware of the consequences of using social media platforms to post content which conflicts with information provided to the ICB, including their health and fitness to work, and secondary employment (for example, posting evidence of undertaking unapproved secondary employment whilst receiving sick pay from the ICB). If an instance such as this occurs, an employee may be subject to criminal or disciplinary proceedings, which could result in dismissal.

17 References, acknowledgements and associated documents

The following related documents may be accessed through the ICB website:

https://bnssgICB.nhs.uk/

BNSSG Information Governance Policy

BNSSG Freedom of Information Policy

BNSSG Individual Rights Policy

Information Security Policy

ICT Disposal Policy

The following related documents may be accessed through the links provided:

NHS England Records Management Code of Practice August 2023

Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk)

UK General Data Protection Regulation (GDPR)

https://www.legislation.gov.uk/eur/2016/679/contents

Freedom of Information Act 2000

https://www.legislation.gov.uk/ukpga/2000/36/contents

Data Protection Act 2018

https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Access to Health Records Act 1990

https://www.legislation.gov.uk/ukpga/1990/23/contents

Freedom of Information Act Section 46 Code of Practice

section-46-code-of-practice-records-management-foia-and-eir.pdf (ico.org.uk)

18 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation plan

Appendix 3 Retention and Disposal of Records Log (Archived Records Log)

Appendix 4 Archive Protocol

Appendix 5 ICB retention schedule

18.1 Equality Impact Assessment

Other documents required to complete the Equality & Health Inequality Impact Assessment:

- **Equality & Health Inequality Impact Assessment Guidance**
- **Equality & Health Inequality Impact Assessment Resources**

Title of proposal: Records Management Policy				Date: 19/10/23
x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
EHIA type:	Screening EHIA x	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x EIA undertaken on previous policy version
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? All BNSSG ICB employees				
Lead person(s) completing this assessment: Lucy Powell				
Lead person job title(s) and service area: Corporate Support Officer				

Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

This is an update to the current Records Management policy in line with best practice and national guidance. The aim is to ensure that all employees understand the arrangements that BNSSG ICB has in place for management of records. This policy aims to provide clear guidance in relation to the actions required by employees to manage BNSSG ICB records, throughout their life cycle from creation to disposal.
Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy will not directly impact Health Inequalities
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A The policy describes the ICB's statutory responsibilities which support compliance with the legal and professional obligations set out for records. There has been no engagement with patients/members of the public in preparing this policy beyond that undertaken by NHS England and the Government as part of other legislative processes
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy has been written with a view to be accessible to employees. Additional information will also be provided on the Hub and the Corporate Governance team will be available to support as required.

Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker – references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3. In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationship between protected groups; you must also have due regard to the principles of the Armed Forces Act 2021 including regarding the unique obligations and sacrifices they make, removing disadvantage and making special provision to ensure services and employment opportunities are accessible.

Positive Impact:				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: There is no positive impact on those holding protected characteristics. The policy outlines the arrangements that BNSSG ICB has in place for the management of records. This policy aims to provide clear guidance in relation to the actions required to comply. The policy applies to all employees and good records management has a positive impact on all staff, who will be able to work more efficiently, and all members of the public, who will be able to request and receive records as needed.				
Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation

☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: It is not believed that the content of the policy would have a direct negative impact on those holding protected characteristics. The ICB has a duty to provide the policy in various formats as required to ensure equitable access to the information within the policy. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' This EHIA is being undertaken as part of the review process for a current ICB policy. There have been no significant amendments made to the processes already in place.				

Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the 'playing field' for all people

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
N/A		

Outline any benefits of the proposal for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

To eliminating discrimination, harassment and victimisation.	Positive	X
	Negative	☐
	No effect	☐
Please describe: This policy supports information rights processes which provide people with access to information held by the ICB as well as their personal data. These rights support the understanding of both the ICB and the NHS as well as transparency of process. These rights also support individuals to have more control over and understanding of their personal data.		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	☐
	No effect	☐
Please describe: The policy applies to all employees. The aim is to ensure that everyone understands the arrangements that BNSSG ICB has in place for the management of records and provides clear guidance in relation to the actions required.		

To foster good relations between people who share a protected characteristic and those who don't (e.g. does the project raise any issues for community cohesion, or linked to current topics that are contentious in society; will it affect relationships between any groups)	Positive	☐
	Negative	☐
	No effect	x
Please describe:		

Action Plan

What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead
Senior support and promotion of the policy	From ICB Board approval on the 1st February 2024	ICB Board approval and subsequent promotion at staff meetings and through staff newsletters	RH/LP

How and when will you review the action plan (include specific dates)?

As part of the quarterly promotion of the policy

What are the main conclusions of this Equality & Health Inequality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have been taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EHIA has informed, influenced or changed the proposal and include a recommendation for the decision maker:

The policy is for all employees and the arrangements outlined support the ICB's legal requirements. The EHIA has highlighted the importance of promotion of the policy

Select a recommended course of action:	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group	x
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service	☐
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions	☐

Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place	☐

All Equality & Health Inequality Impact Assessments should be reviewed internally and obtain sign off to show an organisational commitment.

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Equality Officer Name:
Equality and Inclusion Team Signature:
Date:

Equality Delivery System 2022

Equality, Diversity & Inclusion is an evidence-based practice, Healthier Together partners are committed to demonstrating how we have taken steps to improve patient and service user access, experience and outcomes and how we have created an inclusive working environment for our staff, including supporting our workforce to have healthy and fulfilled lives. Please indicate which Domain your project will deliver against:

Domain 1 – Commissioned & Provided services

- 1A: People can readily access the service.
- 1B: Individual people's health needs are met
- 1C: When people use the service, they are free from harm.
- 1D:People report positive experiences of the service.

Domain 2 – Workforce health and wellbeing

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long term conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work

Domain 3 – Inclusive Leadership

- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

The policy aims to provide clear guidance to staff on the responsibilities for managing records. Having a clear policy in place with support from the appropriate teams supports Domain 2 with the ICB as a good place to work. Having a clear policy in place also supports Domain 3 as the policy provides a framework for Board/Committee members and senior managers to monitor impact and risk.

18.2 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target end date	Resources Required
ICB Board (including SIRO)	Ensure the ICB Board is aware of ICB's responsibilities and provide assurance that appropriate process is established to ensure legal compliance	Cover paper to the policy to be presented to the ICB Board	Chief of staff	1st Feb 2024	1st Feb 2024	Staff time, Board Members time
Information Asset Owners/ Information Asset Administrators	Ensure awareness of ICB processes and the responsibilities of those designated to management directorate/team records	Internal communications through the Voice Policy to be presented to the IAO/IAA Group	Corporate Support Officer	1st Feb 2024	Ongoing	Staff time
All Staff	Ensure awareness of ICB processes and procedures	Policy to be placed on website following approval and information about the policy and ICB process to be placed on the Hub Information about the policy and ICB process to be communicated through The Voice and staff meetings Records Management is included in the mandatory annual Information Governance training module	Corporate Support Officer /Training manager	1st Feb 2024	Following ICB Board approval Ongoing Ongoing	Staff time, Training Module

18.3 BNSSG ICB Retention and Disposal of Physical Records Log (Archived Records Log)

There is a requirement that the below log is completed to transfer physical records for external storage. Proper completion of the log will allow for physical records in external storage to be identified and simplify the process should these records need to be recovered from storage.

Logged by	Main contact for box content	Iron Mountain Bar Code Number	Major description of contents	Minor Description of Contents	Other detail of contents *(Please ensure enough detail is entered to enable to box to be found again by anyone else)*	Contents List created and saved on S drive	Major Record Type	Record Type *(* denotes common types and is used to bring them to to top of the list)*	Period covered From	To	Date Archived	Retention Period	Date to be Destroyed

18.4 Archive Protocol for physical records

This protocol should be followed for any storage of physical records off site.

All records sent for storage must comply with NHS Retention and Disposal Schedule and the BNSSG ICB Records Management Policy

All records should be stored alphabetically, numerically, or in date order (whichever is appropriate). Do not mix different types of records in one box.

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Appropriate archive storage boxes with lids must be used. These can be obtained from the Corporate Team.

DO NOT overfill boxes – the lid must fit securely.

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Retention and Disposal Schedule must be fully completed (**Appendix 3)**

1 copy to be held by Department

1 copy to be forwarded to Corporate Team

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Iron Mountain transmittal sheet will be completed by Department and a bar code label attached.

1 copy to go to with box when the box is collected

1 photocopy to be retained by the Corporate Team

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Collection to be arranged by the Corporate Team

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A reminder will be issued by Corporate Team to the department to ensure destruction of documentation at an appropriate time

18.5 ICB Retention Schedule

This appendix sets out the retention period for different types of records relating to health and care.

The retention periods set out in the schedule are minimum periods. Record retention can be extended with justification. Retention periods begin when the records ceases to be operational. If the records comes back into use during its retention period then the period will reset and the retention duration will begin from the second period of use.

Health and care records should be reviewed before they are destroyed. This review should take into account:

- Serious incidents which would require records to be retained for longer periods
- Use of the record during the retention period which could extend its retention
- Potential cases for long-terms archival preservation (where records relate to rare conditions or innovative treatment decisions)

The schedule below outlines the types of records likely held by the ICB. The full retention schedule can be found as part of the NHS England Records Management Code of Practice.

Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk)

Record Type	Retention Period	Disposal Action	Notes
Care Records			
Adult health records not covered by any other section in this schedule	8 years	Review and consider transfer to archive	Check for involvements which could extend the retention. This includes medical imaging.
Adult social care records	8 years	Review and destroy if no longer required	

Children's records including midwifery, health visiting and school nursing	Up to 25th or 26th birthday	Review and destroy if no longer required	Retain until 25th birthday or 26th birthday if the patient was 17 when treatment ended. This includes medical imaging.
Electronic Patient Record Systems	Refer to notes	Review and destroy if no longer required	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.
Integrated records – all organisations contribute to the same single instance of the record	Retain for period of longest speciality	Review and consider transfer to archive	The retention time will vary depending upon which type of health and care settings have contributed to the record.
Integrated records – all organisations contribute to the same records, but keep a level of separation	Retain for relevant speciality period	Review and consider transfer to archive	This is where all organisations contribute into the same record system but have their own area to contribute to and the system shows a contemporaneous view of the patient record.
Integrated records – all organisation	Retain for relevant	Review and consider	Organisations keep their own records but can grant 'view only' access to other

keep their own records, but enable them to be viewed by other organisations	speciality period	transfer to archive	organisations to help them provide health and care to patients or service users
Mental health records including psychology records	20 years, or 10 years after death	Review and consider transfer to archive	Covers records made under the Mental Health Act 1983 and 2007 amendments. This applies to records of patients and service users, regardless of whether they have capacity.
Pharmacy			
Controlled drugs – registers	2 years	Review and destroy if no longer required	See Misuse of Drugs Act 2001 for more information
Controlled drugs – order books, requisitions etc.	2 years	Review and destroy if no longer required	See Misuse of Drugs Act 2001 for more information
Pharmacy prescription records	2 years	Review and destroy if no longer required	A record of the prescription will also be held on the NHS BSA and there will be an entry on the patient records. Further guidance can be found on the Specialist Pharmacy Service website.
Event and Transaction Records			
Clinical Audit	5 years	Review and destroy if no longer required	Five years from the year in which the audit was conducted. This includes the reports and data collection sheets/exercise.
Datasets released by NHS England and its predecessors	Delete with immediate effect	Delete in line with instructions and guidance on the retention	

Including NHS Digital		and disposal of data as issued through the Data Access Request Service (DARS) process	
Destruction certificates, or electronic metadata destruction stub, or record of clinical information held on physical media	20 years	Review and destroy if no longer required	Destruction certificates created by public bodies are not covered by a retention instrument. They need to be destroyed after 20 years.
Equipment maintenance logs	11 years	Review and destroy if no longer required	
Inspection of equipment records	11 years	Review and destroy if no longer required	
Referrals – NOT ACCEPTED	2 years	Review and destroy if no longer required	Retention period begins from the DATE OF REJECTION.
Requests for care funding – NOT ACCEPTED	2 years	Review and destroy if no longer required	Retention period begins from the DATE OF REJECTION.
Research			

Research – datasets	No longer than 20 years	Review and consider transfer to place of deposit	
Research – ethics committee's and HRA approval documentation for research proposal and records to process patient information without consent	5 years	Review and consider transfer to place of deposit	This applies to trials where opinions are given to proceed with the trial, or not to proceed
Research – ethics committee's minutes (including records to process patient information without consent)	20 years	Review and consider transfer to place of deposit	Retention period begins from the year to which they relate and can be as long as 20 years. Committee minutes must be transferred to a place of deposit
Corporate Governance			
Board meetings	Up to 20 years	Review and transfer to place of deposit	A local decision can be made on how long to retain the minutes of board meetings (and associated papers linked to the board meeting), but this must not exceed 20 years, and will be required to be transferred to the local place of deposit
Board meetings (closed boards)	Up to 20 years	Review and transfer to place of deposit	Although these may still contain confidential or sensitive material, they are still a public record and must be transferred at 20 years, and any FOI exemptions noted, or indications that the duty of confidentiality applies.

Chief Executive records	Up to 20 years	Review and transfer to place of deposit	This may include emails and correspondence where they are not already included in board papers.
Committees (major) – listed in Scheme of delegation or report direct into the board (including major projects)	Up to 20 years	Review and transfer to place of deposit	
Committees (minor) – not listed in scheme of delegation*	6 years	Review and consider transfer to place of deposit	Includes minor meetings, projects and departmental business meetings. These may have local historical value and require transfer consideration.
Data Protection Impact Assessments (DPIAs)	6 years	Review and destroy if no longer required	Should be kept for the life of the activity to which it relates, plus six years after that activity ends. If the DPIA was one -off, then 6 years from completion.
Destruction certificates or record of information held on destroyed physical media	20 years	Review and destroy if no longer required	Where a record listed for potential transfer to the place of deposit has been destroyed without adequate appraisal, consideration should be given to a selection of these as an indicator of what has not been preserved.
Electronic metadata destruction stubs			Refer to destruction certificates
Incidents – serious	20 years	Review and consider transfer to place of deposit	Retention begins from the date of the Incident – not when the incident was reported.
Incidents – not serious	10 years	Review and destroy if no	Retention begins from the date of the Incident – not when the incident was reported.

		longer required	
Incidents – serious incidents requiring investigation	20 years	Review and consider transfer to place of deposit	These include independent investigations into incidents. These may have permanent retention value.
Non-clinical QA records	12 years	Review and destroy if no longer required	Retention begins from the end of the year to which the assurance relates
Patient advice and liaison service (PALS) records	10 years	Review and destroy if no longer required	Retention begins from the close of the financial year to which the records relates
Patient surveys – individual returns and analysis	1 year after return	Review and destroy if no longer required	May be required again is analysis is reviewed
Patient surveys – final report	10 years	Review and consider transfer to place of deposit	Organisations may want to keep final reports for longer than the raw data and analysis, for trend analysis over time. This period can be extended, provided there is justification and organisational approval.
Policies, strategies and operating procedures – including business plans	Life of organisation plus 6 years	Review and consider transfer to place of deposit	Retention begins from when the document is approved, until superseded. If the retention period reaches 20 years from the date of approval, then consider transfer to the place of deposit
Risk Registers	6 years	Review and destroy if no longer required	Retention period in accordance with the Limitation Act and corporate awareness of risks
Staff surveys – individual returns and analysis	1 year after return	Review and destroy if no	Forms are anonymous so do not contain Personal Identifiable Dara unless provided

		longer required	in free space boxes. May be reviewed again if analysis is reviewed.
Staff surveys – final report	10 years	Review and consider transfer to place of deposit	Organisations may want to keep final reports for longer than the raw data and analysis, for trend analysis over time. This period can be extended, provided there is justification and organisational approval.
Communications			
Intranet site	6 years	Review and consider transfer to place of deposit	
Patient information leaflets	6 years	Review and consider transfer to place of deposit	These do not need to be leaflets from every part of the organisation. A central copy can be kept for potential transfer.
Press releases and important internal communications	6 years	Review and consider transfer to place of deposit	Press released may form a significant part of the public record of an organisation which may need to be retained.
Public consultations	5 years	Review and consider transfer to place of deposit	Whilst these have a shorter retention period, there mat be a wider public interest in the outcome of the consultation (particularly where this resulted in changes to the services provided) and so may have historical value
Website	6 years	Review and consider transfer to place of deposit	Websites are complex objects, but regular crawls can be undertaken. Guidance can be found: www.nationalarchives/webarchive/guidance/
Staff Records and Occupational Health			

Occupational health records	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	Review and destroy if no longer needed	
Occupational health report of a staff member under health surveillance	Keep until 75th birthday	Review and destroy if no longer needed	
Occupational health report of staff member under health surveillance where they have been subject to radiation doses	50 years from the date of the last entry or until 75th birthday, whichever is longer	Review and destroy if no longer needed	
Staff record	Keep until 75th birthday	Review and consider transfer to place of deposit	This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms.
Staff record – summary	Keep until 75th birthday	Review and consider transfer to place of deposit	
Timesheets	2 years	Review and if no longer needed destroy	Retention begins from creation

Staff training records	See notes	Review and consider transfer to place of deposit	Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The following is recommended: clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer statutory and mandatory training records - to be kept for ten years after training completed other training records - keep for six years after training completed
Disciplinary records	6 years	Review and if no longer needed destroy	Retention begins once the case is heard and any appeal process completed. The record may be retained for longer, but this will be a local decision based on the facts of the case. The more serious the case, the more likely it will attract a longer retention period. Likewise, a one-off incident may need to only be kept for the minimum time stated. This applies to all cases, regardless of format.
Procurement			
Contracts sealed or unsealed	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Contracts – financial approval files	Retain for 15 years after the end of the contracts	Review and if no longer needed destroy	

Contracts – financial approved suppliers documentation	Retain for 11 years after the end of the contracts	Review and if no longer needed destroy	
Tenders (successful)	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Tenders (unsuccessful)	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Estates			
Building plans, including records of major building works	Lifetime (or disposal) of building plus 6 years	Review and consider transfer to place of deposit	Building plans and records of works are potentially of historical interest and where possible, should be kept and transferred to the local place of deposit
Closed circuit television (CCTV)	Refer to SCW IG team for guidance	Review and destroy if no longer required	The length of retention must be determined by the purpose for which the CCTV has been used. CCTV footage must remain viewable for the length of time it is retained, and where possible, systems should have redaction or censoring functionality to be able to blank out the faces of people who are captured by the CCTV, but not subject to the access request, for example, police reviewing CCTV as part of an investigation
Equipment monitoring, and testing and maintenance where	40 years	Review and destroy if no longer required	Retention begins from the completion of the monitoring or testing. This includes records of air monitoring and health records relating to asbestos

ASBESTOS is a factor			exposure, as required by the Control of Asbestos Regulations 2012.
Equipment monitoring – general testing and maintenance work	Lifetime of installation	Review and destroy if no longer required	Retention begins from the completion of the monitoring or testing.
Inspection Reports	Lifetime of installation	Review and destroy if no longer required	Retention begins as the END of the installation period Building inspection records need to comply with the Construction (Design and Management) Regulations 2015
Leases	12 years	Review and destroy if no longer required	Retention begins at point of lease termination
Minor building works	6 Years	Review and destroy if no longer required	Retention begins at the point of WORKS COMPLETION
Photographic collections – service locations, events and activities	Up to 20 years	Review and consider transfer to place of deposit	These provide a visual historical legacy of the running and operation of an organisation. They may also provide secondary uses, such as use in public inquiries.
Surveys – building or installation (not patient surveys)	Lifetime of installation of building	Review and consider transfer to place of deposit	Retention period begins at the END of the INSTALLATION period
Finance			
Accounts	3 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate. Includes all associated documentation and records for the purpose of audit.

Benefactions	8 years	Review and consider transfer to place of deposit	These may already be in the financial accounts and may be captured in other reports, records or committee papers. Benefactions, endowments, trust fund or legacies should be offered to the local place of deposit.
Debtors records – CLEARED	2 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Debtors records – NOT CLEARED	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Donations	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Expenses	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Final annual accounts report	Up to 20 years	Review and transfer to place of deposit	These should be transferred when practically possible, after being retained locally for a minimum of 6 years. Ideally, these will be transferred with board papers for that year to keep a complete set of governance papers.
Financial transaction records	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Invoices	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.

Petty cash	2 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Private Finance Initiative (PFI) files	Life time of PFI	Review and consider transfer to place of deposit	Retention begins at the END of the PFI agreement. This applies to the key papers only in the PFI.
Staff salary information or files	10 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Superannuation records	10 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Legal, Complaints and Information Rights			
Complaints – case files	10 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the complaint. The complaint is not closed until all processes (including potential and actual litigation) have ended. The detailed complaint file must be kept separately from the patient file (if the complaint is raised by a patient or in relation to). Complaints files must always be separate.
Fraud – case files	6 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the case. This also includes cases that are both proven and unproven.
Freedom of Information (FOI) requests, responses to the request and	3 years	Review and destroy if no longer required	Retention begins from the CLOSURE of the FOI request. Where redactions have been made, it is important to keep a copy of the response as well as the redacted response sent to the requestor. In all cases, a log

associated correspondence			must be kept of requests and the response sent.
FOI requests – where there has been an appeal	6 years	Review and destroy if no longer required	Retention begins from the CLOSURE of the appeal process.
Industrial relations – including tribunal case records	10 years	Review and consider transfer to place of deposit	Retention begins at the CLOSE of the financial year to which it relates. Some organisations may record these as part of the staff record, but in most cases, they should form a distinctive separate record (like complaints files).
Litigation records	10 years	Review and consider transfer to place of deposit	Retention begins at the CLOSURE of the case. Litigation cases of significant or major issues (or with significant, major outcomes) should be considered for transfer. Minor cases should not be considered for transfer.
Intel, patents, trademarks, copyright, IP	Lifetime of patent, or 6 years from the end of licence or action	Review and consider transfer to place of deposit	Retention begins at the END of lifetime or patent, or TERMINATION of licence or action.
Software licenses	Lifetime of software	Review and destroy if no longer required	Retention begins at the END of the lifetime of software
Subject Access Requests (SAR), response, and subsequent correspondence	3 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the SAR
SAR – where there has been an appeal	6 years	Review and destroy if no longer required	Retention begins at CLOSURE of appeal