Ashford and St. Peter's Hospitals NHS
NHS Trust

RECORDS MANAGEMENT POLICY

Amendments			
Date	Page(s)	Comments	Approved by
Oct 06	All	Minor amendments	Director of Information
Oct 06	Page 7 onwards	Records Retention Schedule replaced in its entirety	Director of Information
		Section 1 – reference to legislation	
Sep 07	Page 3	Section 3 – new section	Director of Performance, Information and Facilities
	Page 3	Section 4 – new section	
	Page 4	Section 10 – reference to FOI	
	Page 7	Section 11 – new section	
	Page 7	Appendix E – new section	
	Page 36		
Jan 09	Page 2	'See Also' section - updated	Chief Executive
	Page 4	Section 5 – updated with new standards	Chief Executive
	Page 6	Section 8 – reference to Microfiche removed	Chief Executive
	Page 7	Section 10 – reference to subject access team inserted	Chief Executive
	Page 7	Section 10 – Act clarified as FOI	Chief Executive
	Page 7	References – updated with new code of practice part 2	Chief Executive
	Page 9	Appendix A – New section, record keeping standards	Chief Executive
	Page 10	Appendices B – F updated in line with NHS ~Code of Practice Part 2.	Chief Executive
	Page 56	Appendix G – deleted as now incorporated with Appendix A and section 5.	Chief Executive
Aug 09	Page4	Section 4 updated to include electronic records	
	Page 8	Section 13 updated to include training details	

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Sue Hookins, Patient Access Manager

Ratified by: Management Board

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Reviewed by: Cath Jago, Head of Information Services

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Impact Assessment Carried Out By : Cath Jago

Contact name for details: Cath Jago, Head of Information Services

ASHFORD & ST. PETER'S HOSPITALS NHS TRUST

RECORDS MANAGEMENT POLICY

Table of Contents

See also: Freedom of Information Policy
Standard Operating Policy for Health Records
Confidentiality Policy

1. INTRODUCTION

All NHS records are public records under the terms of the Public Records Act 1958 which confers a statutory duty on Trusts for their safekeeping and eventual disposal.

The Department of Health Records Management: Code of Practice is 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 England. It clarifies legal obligations that apply to NHS records including responsibilities to ensure compliance with the following acts.

- The Data Protection Act 1998
- The Freedom of Information Act 2000

2. PURPOSE AND SCOPE OF THE POLICY

This policy identifies the actions required to ensure that records of all types (administrative as well as medical) are properly controlled, readily accessible and available for use, and eventually archived or otherwise appropriately disposed of.

For the purposes of this policy, a record is defined as anything which contains information (in any medium) which has been created or gathered as a result of any aspect of the work of NHS employees. The definition covers all clinical and non-clinical records.

3. ROLES AND RESPONSIBILITIES

Chief Executive

The Chief Executive has overall responsibility for records management in the Trust. The Trust has a particular responsibility for ensuring that it corporately meets its legal responsibilities and for the adoption of internal and external governance requirements.

Local Managers

The responsibility for local records management is devolved to the relevant directors, unit managers and department managers for the management of records generated by their activities.

Caldicott Guardian

The Trust's Caldicott Guardian has a particular responsibility for safeguarding patients' interests regarding the use of patient identifiable information.

Head of Information/Records Management Committee

The Head of Information/Records Management Committee is responsible for ensuring that:

- a Records Management Policy is implemented;
- a Records Management system and processes are developed, co-ordinated and monitored.

Health Records Manager

The Health Records Manager is responsible for the overall development and maintenance of health records management practices throughout the Trust, including:

- best practice guidance for records management;
- promoting compliance with policies to ensure the easy, appropriate and timely retrieval of patient information.
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All 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;
- manage those records;
- comply with the Records Management Policy and guidance.

4. RECORD CREATION

Each operational unit (eg Finance, Estates, IT, healthcare) should have a process for documenting its activities, taking into account the legislative and regulatory environment in which it operates

All records should be complete and accurate:

- to allow staff to undertake appropriate actions in the context of their responsibilities;
- to facilitate audit;
- to protect legal and other rights of the organisation, patients, staff and other people affected;
- to show proof of validity and authenticity.

Records should have a logical filing structure to enable the quick and efficient filing and retrieval of records when required .

Electronic Records

All staff should have access to a G:drive, this is an area of the network accessible to all members of your department. All records which are to be shared with the rest of your department should be saved on your G: drive

Where records are to be shared across departments, a folder should be set up on the T: drive (St Peter's) or U: drive (Ashford) and the records saved there

The IT Department will set up the folders and give controlled access to them

Documents that are personal to you, including Outlook Personal Folder should be saved to your H: drive so that only you have access.

All records should have a logical filing structure

- Give a unique name to each record
- Give a meaningful name which reflects the records contents
- Put elements of the name in a structured and predictable order
- The most specific information should be at the beginning of the name
- Give a similarly structured and worded name to records which are linked

e.g. Records Management-working group-final report
is more useful than
Final report of the working group on Records Management.

Referencing

Each operational unit should use a referencing system that meets its business needs and can easily be understood by staff members who create records. E.g. alphanumeric- HR for Human Resources

Protective Markings

All records regardless of media may be classified to reflect their status. They should be appropriately marked into different categories such as

- Draft
- Confidential
- Sensitive
- Private

This enables the record to be handled appropriately at all the stages of its lifecycle.

If a protective marking is required this should be typed as a watermark across the record.

Version Control

Version control is a process which leaves a clear audit trail of change to the record. Version control is important for electronic records as they can easily be changed.

The original should be numbered as 1.0 and subsequent versions should be numbered consecutively.

This information should be recorded on the front cover and in the footer bar.

5. RECORD KEEPING STANDARDS

Record keeping is a tool of professional practice and one which should help the care process. It is not separate from the process and it is not an optional extra to be fitted in. Professional organisations all have standards for record keeping which covers all formats (eg paper, electronic format).

Generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical note keeping. These standards were developed by the health Informatics Unit of the Royal College of Physicians following review of published standards and wide consultation. They were first published in 2007 in Clinical Medicine.

Purpose of the Standards:

- To Maximise patient safety and quality of care
- Support professional best practice
- Assist compliance with Information Governance and NHS Litigation Authority (CNST) Standards.

The 12 Record Keeping Standards are detailed in Appendix A.

These Record Keeping Standards as mentioned above are to be adhered to as well as the standards detailed below which have been agreed locally by the Trust:

- All entries are full, factual, consistent, contemporaneous, accurate and legible;
- Written in black pen (not ink, as ink will run if it comes into contact with a liquid) and on white paper, (although other coloured pens and paper can be used providing the combination of pen and paper produces a legible and permanent record);
- Written clearly and in such a way that the text cannot be erased;
- Signatures to be accompanied by a name written in Capital letters;
- Any alterations or additions are dated, timed and countersigned in such a way that the original entry can still be read clearly – errors are scored through with a single line and signed, no use of correction fluid;
- Free from abbreviations (unless officially accepted and in accordance with authorised Trust/local list)
- Free from jargon, meaningless phrases, irrelevant speculation, judgemental, offensive, subjective or unprofessional statements or language;
- All entries by unqualified staff are countersigned by a registered professional;
- Any photocopies should be clearly legible;

- All documentation and charts are labelled on every page with the patient identification;
- Registered professionals are aware that patients are normally entitled to access their records.

6. RECORD STORAGE

On-site Storage

All records will be kept in a secure storage area for which access restrictions will apply as appropriate.

Where there is a tracking system in use, all records should be tracked to their location and stored in a secure way.

All records will be filed in a way that facilitates their location and retrieval.

Wherever possible central storage should be established.

Off-site Storage

When records are no longer required for operational purposes, they may be sent to a secure off-site storage facility, under contractual arrangements that must comply with relevant legislation and guidance.

The criteria for deciding when a record should be sent off-site will take into account amongst other things the last time the record was required for operational purposes, on-site storage availability, and the likelihood of the record being required for operational purposes again.

Requests for the return of records will be controlled by an appropriate Trust manager.

7. RECORD MOVEMENT

Requests for the provision of records (both routine and urgent) should be directed towards the appropriate managers who are responsible for their storage.

The physical movement of records within the buildings of the Trust will be undertaken in a safe and secure way.

The routine transport of records between the Trust locations and to other local hospitals will be via the internal transport system.

Arrangements for the urgent transport of records between Trust locations and the routine transport of records to other destinations not covered by the Trust transport service will be left to the discretion of the local manager who will be responsible for their safe delivery and receipt.

Where records/documents (including x-rays) are requested by another organisation, a copy of the originals is sent and the originals retained at the Trust. The copy must be clearly marked as “copy”.

Original records should not be removed off site apart from in the most exceptional circumstances when transported between Trust sites in the personal custody of a consultant or senior manager, and this movement tracked accordingly.

Records may not be taken home or to the residencies under any circumstances.

Records must not be left in a car, other vehicle or left unattended whils***t*** off-site.

Transport of records to and from off-site storage facilities will be covered under the contractual arrangements.

All record movement will be recorded on a tracking system.

8. RETENTION AND DESTRUCTION OF RECORDS

The retention period depends upon the type of record and its importance to the Trust. The DoH provides guidance in the Records Management NHS Code of Practice which sets out the minimum retention period for both clinical and administrative records. See Appendices for detailed guidance.

The decision to dispose of records will be taken by a relevant Trust senior manager (eg Clinical records by the Health Records Manager, administrative records by the Head of Department) only after the minimum retention period has been exceeded.

Where there is any reason to believe or suspect that a complaint may be received or legal action may be initiated relating to a period or episode covered by the record, then the entire record(s) should be retained even after the minimum retention period. If necessary, the advice of the Trust's legal services manager should be sought.

Options for the disposal of paper records include:

- digitizing for electronic storage
- depositing with a Public Records body
- transferring to a bona-fide research body recognised by the Local Research Ethics Committee
- destruction

It is the responsibility of the Trust to satisfy itself that records are destroyed in a way that safeguards against accidental loss or disclosure of contents.

This will normally involve an approved contractor shredding, pulping or incinerating records, and providing written certification as proof of destruction.

9. CONFIDENTIALITY AND SECURITY OF RECORDS

The storage, distribution, use and disposal of records will conform to relevant legislation (eg Data Protection Act 1998, Human Rights Act 1998), guidance (eg Caldicott, BS7799), local policies (eg the Trust Confidentiality Policy) and take account of best practice.

A clear desk/screen policy will be promoted, to prevent unauthorised access.

Appropriate physical security measures will be in place to control access to work areas where records are stored or used.

A written procedure to locate or replace missing records will be followed.

Where a record cannot be found, it should be reported on an incident report form and forwarded to the Risk Manager and Directorate/Department Manager.

A periodic sample audit of patient case note files (looking at amongst other things condition, content and location) will be undertaken by relevant managers with results reported to the Records Management Committee.

10. ACCESS TO RECORDS

Under the Data Protection Act 1998, the right of "subject access" allows an individual to gain access to personal data held about them. Typically, this will involve supplying an individual with access to or a copy of their record when asked to do so. The Access to Health Records Act 1990 applies to requests for access or a copy of records of deceased patients by their personal representatives.

Although it is good practice to share the contents of a record with the data subject as personal data is being recorded, the individual can apply for access to that record at any time.

Formal requests for access should be made in writing to the Trust's, Subject Access Team. A fee may be payable. Access to a personal record will be facilitated within 21 or 40 days as appropriate.

Personal data contained within a record may be shared with other people, subject to that conforming to the second principle of the Data Protection Act 1998, which requires the disclosure to be compatible with the express purpose for which that data was obtained.

The Freedom of Information Act 2000 gives a general right of access from 1 January 2005 to recorded information held by public authorities, subject to certain conditions and exemptions.

In accordance with section 8 of the Freedom of Information Act, a request for information under the general rights of access must be received in writing, stating the name of the applicant and an address for correspondence, and describes the information requested. For the purpose of general rights of access, a request is to be treated as made in writing if it is transmitted by electronic means, is received in legible form and is capable of being used for subsequent reference.

The Trust will establish systems and procedures to ensure that the organisation complies with the duty to confirm or deny and to provide the information requested within 20 working days of a request in accordance with section 10 of the Freedom of Information Act.

11. MONITORING

This Policy will be monitored as a whole for example, an organisation-wide, multi-professional audit of clinical record-keeping standards for all professional groups in all specialties will be undertaken on an annual basis. The criteria for the Health Records Audit is detailed in Appendix E (as documented in the Trust's Standards for Practice and Care). The results of the audit are fed back to healthcare professionals via the Clinical Effectiveness and Audit Committee and the relevant area tasked to produce an action plan to improve and maintain performance.

The audit report will give an overview of health records management, detail the methodology used and publish results with recommendations where appropriate.

12. EQUALITY IMPACT ASSESSMENT

See Appendix H

13. TRAINING

New staff will receive familiarisation training at induction.
Subsequent training will be identified through the appraisal process.

Courses available include:

File Management
Getting Started
Understanding Windows

All are available by contacting the Minerva Centre on ext 2938

The IT Department also provide a leaflet called 'Guide to IT' and a booklet called 'Guide to IT at Ashford and St Peter's Hospitals NHS Trust'
Copies of these can be viewed or downloaded using the links below

http://trustnet/departments/minerva/Guide_to_IT.pdf

http://trustnet/departments/minerva/Guide_to_IT.doc

14. REVIEW

The Records Management policy will be reviewed annually.

REFERENCES

Nursing and Midwifery Council Standards for Records and Record Keeping 1998
General Medical Council Good Medical Practice 1998
Health Quality Service Accreditation Programme
Department of Health Records Management: NHS Code of Practice – Part 1
Department of Health – Records management: NHS Code of Practice (Part 2 – 2nd Edition)

Connecting for Health Information Governance Toolkit
Standards for Practice and Care

APPENDIX A : RCP APPROVED 'GENERIC MEDICAL RECORD KEEPING STANDARDS'

Prepared by the Health Informatics Unit of the Royal college of Physicians

Generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical note keeping. These standards were developed by the Health Informatics Unit of the Royal college of Physicians following review of published standards and wide consultation. They were first published in 2007 in Clinical Medicine.

Standard	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (NHS Number) (1) and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma (2)
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned
7	Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why (3)
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney
Notes:	
1	The NHS number is being introduced as the required patient identifier.
2	This standard is not intended to mean that handover proforma should be used for every handover of every patient rather that any patient handover information should have a standardised structure.
3	The maximum interval between entries in the record would in normal circumstances be one (1) day or less. The maximum interval that would cover a bank holiday weekend, however, should be four (4) days.

APPENDIX B : HEALTH RECORDS RETENTION SCHEDULE

This retention schedule details a Minimum Retention Period for each type of health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. Where a retention period longer than 30 years is required (eg to be preserved for historical purposes), or for any pre-1948 records, The National Archives (see note 1 below) should be consulted. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound, and including all records of NHS patients treated on behalf of the NHS in the private healthcare sector):
patient health records (electronic or paper-based, and concerning all¡ specialties, including GP medical records);
records of private patients seen on NHS premises;
Accident & Emergency, birth and all other registers;
theatre, minor operations and other related registers;
X-ray and imaging reports, output and images;
photographs, slides and other images;
microform (ie microfiche/microfilm);audio and video tapes, cassettes, CD-ROMs, etc;
e-mails;
computerised records; and
scanned documents.
If viewed in electronic format, the search facility in Word or PDF can be used to search for particular record types.

Notes

Where an organisation has an existing relationship with an approved Place of Deposit, it should consult the Place of Deposit in the first instance. Where there is no pre-existing relationship with a Place of Deposit, organisations should consult The National Archives.

The coding below denotes the status of the type of record and its retention period:

C = a previously existing record type (ie referenced in the previous retention schedule dated March 2006) but a Change to the retention period

N =a New record type (either not referenced in the previous retention schedule or a more explicit description of a record type than previously published)

S = a previously existing record type, with the Same retention period.

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
A&E records (where these are stored separately from the main patient record)	Retain for the period of time appropriate to the patient/ specialty, eg children's A&E records should be retained as per the retention period for the records of children and young people		Destroy under confidential conditions	S
A&E registers (where they exist in paper format)	8 years after the year to which they relate		Likely to have archival value. See note 1	S
Abortion – Certificate A (Form HSA1) and Certificate B (Emergency Abortion)	3 years		Destroy under confidential conditions	S
Admission books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. See note 1	S
Adoption records (administrative) – see non-health records				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Pre-Adoption Records	Records, where the NHS number has been changed following adoption, will be returned to the appropriate PCT and they should be retained securely and confidentially for the same period of time as all records for children and young people. Genetic information should be transferred across to the post-adoption record. Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions	N
Ambulance records –patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	10 years (applies to ALL Ambulance Clinical Records) NB Where a patient is transferred to the care of another NHS organisation all relevant clinical information must be transferred to the patients' health record held at that organisation)	Limitation Act	Destroy under confidential conditions	N
Angiography tapes and disks	8 years		Destroy under confidential conditions	N
Asylum seekers and refugees (NHS personal health record – patient-held record)	Special NHS record – patient held – no requirement on NHS to retain			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Audio tapes of calls requesting care (PCT, GP, NHS Direct Records etc)	Retain taped calls for 3 years providing all relevant clinical information has been transferred to the appropriate patient record. Where the information is NOT transferred into a health record, the tapes should be retained for 10 years.	Limitation Act 1980	Destroy under confidential conditions	N
Audiology records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Audit Trails (Electronic Health Records)	NHS organisations are advised to retain all audit trails until further notice.		Destroy under confidential conditions	N
Autopsy records – see Post mortem records and registers				
Birth registers (ie register of births kept by the hospital)	Lists sent to General Register Office on a monthly basis. Retain for 2 years		Likely to have archival value. See note 1	S
Birth Notification (to Child Health Department)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Blood transfusion records (see pathology records)				
Body release forms	2 years		Destroy under confidential conditions	S
Breast screening X-rays (see Mammography Screening)				
Care records –compiled by employees of a Care Trust (including information on an individual's educational status, care needs, etc)	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Cervical screening slides	10 years		Destroy under confidential conditions	S
Chaplaincy records	2 years		Likely to have archival value. See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Child and family guidance	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Child Health Record	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions	N
Child Health Records (notification of Visitors/New Entrants into a borough either from abroad, or from within the UK from Airports, the Home Office Immigration Centre and the Housing Options Teams)	Database of notifications – entries should be retained for 2 years Where a health visitor visits the child the record of the visit should become part of the patient's record and retained until their 25th birthday or 26th birthday if an entry was made when the patient was 17 or 10 years after the patient's death if patient died while in the care of the organisation. This also applies to any other information that relates to patient care recorded by the health visitor for these purposes. Other information should be retained for a period of 2 years from the end of the year to which it relates.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Child Protection Register (records relating to)	Retain until the patient's 26th birthday or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	C
Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions	S
Clinical audit records	5 years		Destroy under confidential conditions	S
Clinical Protocol (GP, in-house)	25 years		Destroy under confidential conditions	N
Clinical psychology	20 years		See note 1	C
Clinical trials (see research records)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Contraception and Sexual Health Records (Including where a scan is undertaken prior to termination of pregnancy but the patient goes elsewhere for the procedure)	8 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Controlled drug documentation (Moved from Pharmacy Records)	Requisitions – 2 years Registers and CDRBs – 2 years from last entry Extemporaneous preparation worksheets – 13 years Aseptic worksheets (adult) – 13 years Aseptic worksheets (paediatric) – 26 years External orders and delivery notes – 2 years Prescriptions (inpatients) – 2 years Prescriptions (outpatients) – 2 years Clinical trials 5 years minimum (may be longer for some trials) Destruction of CDs – 7 years Future Regulations may increase the period of time for the storage of records. Please refer to Department of Health http://www.dh.gov.uk/en/index.htm and Royal Pharmaceutical Society of Great Britain http://www.rpsgb.org.uk/ websites for up-to-date information	Misuse of Drugs Act 1971 Misuse of Drugs Regulations 2001 Safer management of controlled drugs: a guide to good practice in secondary care (England). October 2007, Dept of Health, 17th October 2007 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079618	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Counselling records	20 years or 8 years after the patient's death if patient died while in the care of the organisation	Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 NB "Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient's medical records or in a case-file…." These records are subject to the retention periods in this schedule	See note 1	C
Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis, *including deceased patients*	CJD Incidents Panel	See note 1	S
Death – Cause of, Certificate counterfoils	2 years		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Death registers – ie register of deaths kept by the hospital, where they exist in paper format	Lists sent to GRO on a monthly basis. Retain for 2 years Death registers prior to lists sent to GRO – offer to Place of Deposit		Likely to have archival value. See note 1	S
Dental epidemiological surveys	30 years		Destroy under confidential conditions	S
Dental, ophthalmic and auditory screening records including Orthodontic Records and Models	*Community Records* 11 years for adults For children 11 years or up to their 25th birthday, whichever is the longer *Hospital Records* Adult records – Retain for 8 years Children and young people – Retain until the patient's 25th birthday or26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period	British Dental Association	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
De-registered patients (received by PCT's) – records for	Records for de-registered patients, which are received by the PCT, should be retained for at least 10 years. After the retention period has elapsed a decision must be taken by the PCT as to whether to destroy the records or retain them further.		Destroy under confidential conditions	N
Diagnostic Image Data (for diagnostic imaging undertaken in the private sector under contract to the NHS or private providers treating patients on behalf of the NHS)	Retain for the life of the National Diagnostic Imaging Services Contract and then return the data to the NHS after which the retention period in this retention schedule will apply.	National Diagnostic Imaging Services Contract; Records Management: NHS Code of Practice		N
Diaries – health visitors, district nurses and Allied Health Professionals	2 years after end of year to which diary relates. Patient specific information should be transferred to the patient record. Any notes made in the diary as an 'aide memoire' must also be transferred to the patient record as soon as possible.		Destroy under confidential conditions	N
Did not attend (DNA) see DNA below				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Dietetic and nutrition	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Discharge books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. See note 1	S
Discharge nursing team assessments of homes and nursing homes NB The documents should be part of the patient record as they relate to the discharge of the patient	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation			N
District nursing records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
DNA (health records for patients who **did not attend** for appointments as out-patients)	Where there is a letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given, so this information is also held elsewhere. Retain for 2 years after the decision is made. Where there is **no** letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given. Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation.		Destroy under confidential conditions	N
Donor records (blood and tissue)	30 years post transplantation	Committee on Microbiological Safety of Blood and Tissues for Transplantation (MSBT); guidance issued in 1996	See note 1	S
Drug trials, records (see Research records)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Duplicate patient record notification forms (NHS Direct)	2 years after the decision of whether or not to merge unless there is a business need to retain for longer.		Destroy under confidential conditions	N
Electrocardiogram (ECG) Records	7 years NB Each chart should be labelled with the patient's name and unique identifier. Any over-sized charts could then be stored separately where a report is written into the health records.		Destroy under confidential conditions	N
Endoscopy Records including: Sterilix Endoscopic Disinfector Traceability Strips, Traceability Stickers for PEG/Stents (Endoscopy)	Retain for standard retention periods i.e. 8 years for adults and in the case of children and young people retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Family planning records (See also Contraception and Sexual Health Records)	For records of adults – retain for 10 years after last entry For clients under 18 – retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years	Destroy under confidential conditions	C
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	For post-mortem records which form part of the Coroner's report, approval should be sought from the coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) guidance from the Royal College of Pathologists and the Institute of Biomedical Science: http://www.rcpath.org.uk/resources/pdf/retention-SEPT05.pdf Human Tissue Act 2004	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Genetic records	30 years from date of last attendance	The Royal College of Pathologists endorses the Code of Practice and Guidance of the Advisory Committee on Genetic Testing (1997) and its recommendations on storage, archiving and disposal of specimens and records related to human testing services (genetics) offered and supplied direct to the public. Those who intend to offer such services should follow its guidance	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Genito Urinary Medicine (GUM) Includes sexual health records	For records of adults - retain for 10 years after last entry For clients under 18 - retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists	Destroy under confidential conditions	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
GP records, including medical records relating to HM Armed Forces or those serving a period of imprisonment	GP Records, wherever they are held, other than the records listed below retain for 10 years after death or after the patient has permanently left the country unless the patient remains in the European Union. In the case of a child if the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions	S
	Maternity records – 25 years after last live birth	Limitation Act 1980, Congenital Disabilities (Civil Liability) Act 1976, Consumer Protection Act 1987	Destroy under confidential conditions	S
	Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983 –20 years after the date of the last contact; or 10 years after patient's death if sooner NB GPs may wish to keep mental health records for up to 30 years before review. They must be kept as complete records for the first 20 years but records may then be summarised and kept in summary format for the additional 10-year period	Royal College of Psychiatrists	Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	Records relating to those serving in HM Armed Forces – The Ministry of Defence (MoD) retains a copy of the records relating to service medical history. The patient may request a copy of these under the Data Protection Act (DPA), and may, if they choose, give them to their GP. GPs should also receive summary records when ex-Service personnel register with them. What GPs do with them then is a matter for their professional judgement, taking into account clinical need and DPA requirements – they should not, for example, retain information that is not relevant to their clinical care of the patient Records relating to those serving a prison sentence See also Prison Health Records (below) for guidance on scanning of hospital letters		Not to be destroyed. This refers to GP records of serving military personnel that were inexistence prior to them enlisting. Following the death of the patient, the records should be retained for 10 years after their death. Not to be destroyed. This refers to GP records of serving prisoners that were in existence prior to their imprisonment. After their death, the records should be retained for 10 years.	S S
	Electronic patient records (EPRs) must not be destroyed, or deleted, for the foreseeable future	Good Practice Guidelines for General Practice Electronic Patient Records (version 3.1)	Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Health visitor records	10 years. Records relating to children should be retained until their 25th birthday		Destroy under confidential conditions	S
Homicide/'serious untoward incident' records	30 years		See note 1	S
Hospital acquired infection records	6 years		Destroy under confidential conditions	S
Hospital records (i.e. other non-specific, secondary care records that are not listed elsewhere in this schedule)	8 years after conclusion of treatment or death		Destroy under confidential conditions	N
Human fertilisation records, including embryology records	**Treatment Centres** The following retention periods apply to data held by clinics as established by HFEA Direction D 1992/1: 1. Where it is known that a birth has resulted from treatment – 25 years after the child's birth. 2. Where it is known that no birth has resulted from treatment – 8 years after conclusion of treatment. 3. Where the outcome of treatment is unknown – 50 years after the information was first recorded.	HFEA Data Protection Policy Version 2 Release Date 27/07/2007 http://www.hfea.gov.uk/docs/DP_Policy_-_web.pdf	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	Storage centres Where gametes, etc have been used in research, records must be kept for at least, 50 years after the information was first recorded **Research centre** Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	Directions given under the Human Fertilisation and Embryology Act 1990, 24 January 1992 (this Act is subject to review by the Government: http://www.dca.gov.uk/StatutoryBarsReport2005.pdf) This applies to centres in respect of information which they are directed to record and maintain under a treatment/ storage licence.		S S
Human tissue (within the meaning of the Human Tissue Act 2004) (see Forensic medicine above)	For post mortem records which form part of the Coroner's report, approval should be sought from the Coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years		See note 1	S
Immunisation and vaccination records	For children and young people – retain until the patient's 25th birthday or 26th if the young person was 17 at conclusion of treatment All others retain for 10 years after conclusion of treatment		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Intensive Care Unit charts	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Joint replacement records	10 years For joint replacement surgery the revision of a primary replacement may be required after 10 years and there is a need to identify which prothesis was used originally. There is only a need to retain the minimum of notes with specific information about the original prosthesis for the full 10 years	http://www.njrcentre.org.uk Consumer Protection Act (CPA) 1987 & Section 11A(3) Limitation Act 1980 (in accordance with Section 4 CPA)	See note 1	C
Learning difficulties – (records of patients with) NB Specific Learning Difficulty is where a person finds one particular thing difficult but manages well in everything else	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died whilst in the care of the organisation	Royal College of Psychiatrists	Destroy under confidential conditions	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Learning Disabilities NB A general learning disability is not a mental illness – it is a life-long condition, which can vary in degree from mild to profound	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died whilst in the care of the organisation	Royal College of Psychiatrists	Destroy under confidential conditions	N
Macmillan (cancer care) patient records– community and acute	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Mammography Screening (mammograms and reports)	Normal Packet – *9 years after date of final attendance* Screen detected cancers – *Indefinitely* Interval Cancers – *Indefinitely* Interesting Cases – *Indefinitely* (Based on Royal College guidance) Research Cases – *15 years after date of final attendance* Age Trial Cases – *9 years after date of final attendance* Deaths – *9 years after date of final attendance* Where product liability is involved – *11 years* NB Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record	BFCR(06)4 Royal College of Radiologists Consumer Protection Act 1981	Destroy under confidential conditions	N
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child	See Addendum 1 (*Joint Position on the Retention of Maternity Records*) devised by: British Paediatric Association, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting	Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Medical illustrations (see Photographs below)	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Mental Health Records – Child & Adolescent (includes clinical psychology records) not listed elsewhere in this schedule	20 years from the date of last contact, or until their 25th/26th birthday, whichever is the longer period. Retention period for records of deceased persons is 8 years after death.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Mentally disordered persons (within the meaning of any Mental Health Act)	20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner NB Mental health organisations may wish to keep mental heath records for up to 30 years before review (local decision). Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. This retention period has been intentionally left flexible to allow organisations to determine locally in collaboration with clinicians which option to follow as some organisations have storage problems and are unable to retain for longer than 20 years. The records of all mentally disordered persons (within the meaning of the MH Act) are to be retained for a minimum of 20 years irrespective of discipline e.g. Occupational Therapy, Speech & Language Therapy, Physiotherapy, District Nursing etc) Social services records are retained for a longer period. Where there is a joint mental health and social care trust, the higher of the two retention periods should be adopted	Mental Health Act 1983 and its successors Royal College of Psychiatrists	When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		May have archival value. See note 1	S
Midwifery records	25 years after the birth of the last child	*Midwives rules and standards* 05.04 (rule 9)	Destroy under confidential conditions	S
Mortuary registers (where they exist in paper format)	10 years		See note 1	S
Music therapy records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Neonatal screening records	25 years		Destroy under confidential conditions	S
Nicotine Replacement Therapy (dispensed as smoking cessation aid)	2 years unless there are clinical indications to keep them for longer		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Notifiable diseases book	6 years		Destroy under confidential conditions	S
Occupational health records (staff)	3 years after termination of employment unless litigation ensues (see Litigation)		Destroy under confidential conditions	S
Health records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Control of Substances Hazardous to Health Regulations 2002 (reg. 24(3))	See note 1	S
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	See above (reg. 10(5))	See note 1	S
Personnel health records under occupational surveillance	40 years from last entry on the record	Ionising Radiation Regulations 1999 (reg. 11(3))	See note 1	S
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	See above (reg. 19(3)(a))	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Occupational therapy records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Occupationally Related Diseases e.g. asbestosis, pneumoconiosis, byssinosos)	10 years after date of last entry in the record	British Thoracic Society's Occupational and Environmental Lung Disease Specialist Advisory Group	Destroy under confidential conditions	N
Oncology (including radiotherapy)	30 years The 30 year retention period is the period required by the Public Records Act whereby organisations, which need to retain records for greater than 30 years should consult with their Local Place of Deposit (see note 1 – final action column). For deceased patients records should be retained for 8 years after death. NB Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes	BFCO (96)3 issued by the Royal College of Radiologists with the support of the Joint Council for Clinical Oncology	See note 1	S
Operating Theatre Lists (paper)	4 years (for those lists that only exist in paper format and are the sole record) 48 hours (for prints taken from computer records)			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Operating theatre registers	8 years after the year to which they relate		Likely to have archival value. See note 1	S
Orthoptic records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions	S
Paediatric records (see Children and young people above)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Parent-held records (i.e. records for sick/ ill children being cared for at home by community teams NOT the records of newborn children. These records are NHS records that belong to clinical staff but which are held by the parent.	At the end of an episode of care the NHS organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve parent-held records. The records should then be retained until the patient's25th birthday, or 26th birthday if the young person was 17 at the conclusion of treatment, or 8 years after death		Destroy under confidential conditions	N
Pathology records *Documents, electronic and paper records* Accreditation documents; records of inspections	10 years or until superseded	http://www.rcpath.org/resources/pdf/retention-SEPT05.pdf The retention schedules are under review by the Royal College of Pathologists – check RCP website for updates	Destroy under confidential conditions	S
Batch records results (relating to products)	10 years	Consumer Protection Act 1987		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Blood gas results	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation			N
Bound copies of reports/records, if made	30 years			S
Day books and other records of specimens received by a laboratory	2 calendar years			S
Equipment/ instruments maintenance logs, records of service inspections	Lifetime of equipment			S
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
External quality control records	2 years			S
Internal quality control records (relating to products)	10 years	Consumer Protection Act 1987		S
Lab file cards or other working records of test results for named patients	2 calendar years			S
Near-patient test data	Result in patient record, log retained for lifetime of instrument			S
Pathological archive/ museum catalogues	30 years, subject to consent			S
Photographic records	30 years where images present the primary source of information for the diagnostic process			S
Records of telephoned reports	2 calendar years			S
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Reports, copies Post mortem reports	6 months Held in the patient's health record for 8 years after the patient's death			S
Request forms that are not a unique record	1 week after report received by requestor			S
Request forms that contain clinical information not readily available in the health record	30 years			S
Standard operating procedures (current and old)	30 years			S
Specimens and preparations Blocks for electron microscopy	 30 years			S
Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record			S
Foetal serum	30 years			S
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides – 10 years Residual tissue – kept as fixed specimen once frozen section complete			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Frozen tissue or cells for histochemical or molecular genetic analysis	10 years			S
Grids for electron microscopy	10 years			S
Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)			S
Microbiological cultures	24–28 hours after final report of a positive culture issued. 7 days for certain specified cultures – see RCPath document			C
Museum specimens (teaching collections) Stained slides	Permanently. Consent of the relative is required if it is tissue obtained through post mortem Depends on the purpose of the slide – see RCPath document for further details	http://www.rcpath.org/resources/pdf/Retention-SEPT05.pdf		S
Newborn blood spot screening cards Body fluids/aspirates/ swabs	5 years – parents should be alerted to the possibility of contact from researchers after this period and a record kept of their consent to contact response 48 hours after the final report issued by lab	Code of Practice of the UK Newborn Screening Programme Centre and http://www.screening.nhs.uk/cpd/ICFactsheet4.pdf		S
Paraffin blocks	30 years and then appraise for archival value			S
Records relating to donor or recipient sera	11 years post transplant			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Serum following needlestick injury or hazardous exposure	2 years			S
Serum from first pregnancy booking visit	1 year			S
Wet tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens	Human Tissue Act		S
Whole blood samples, for full blood count	24 hours			S
Transfusion laboratories Annual reports (where required by EU directive)	15 years			S
Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records – copies may only be lodged on the health record with the Coroner's permission			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Blood bank register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive N 2002/98/ EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4ºC			S
Forensic material – criminal cases	Permanently, not part of the health record			S
Refrigeration and freezer charts	11 years			S
Request forms for grouping, antibody screening and crossmatching	1 month	EU Directive 2002/98/ EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used	EU Directive 2002/98/ EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Separated serum/ plasma, stored for transfusion purposes	Up to 6 months			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	http://www.cepath.org/esources/pdf/Retention-SEPT05.pdf		S
Worksheets	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Patient-held records	At the end of an episode of care the NHS organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve patient-held records. The records should then be retained for the period appropriate to the specialty		Destroy under confidential conditions	S
Pharmacy records *Prescriptions* Chemotherapy	Recommendations for the retention of pharmacy records (prepared by the NHS East of England Senior Pharmacy Manager's Network). Notes at the beginning of the retention schedule. 2 years after last treatment (Electronic Patient Records will eventually hold all details)	http://www.pjonline.com//news/recommendations_for_the_retention_of_pharmacy_records	Destroy under confidential conditions	S
Clinical drug trials (non-sponsored)	2 years after the end of the trial			S
FP10, TTOs, outpatient, private	2 years (Electronic Patient Records will eventually hold all details)		NB Inpatient prescriptions held as part of health record	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Parenteral nutrition	2 years (Original valid prescriptionsshould be kept in patient's notes)			N
Unlicensed medicines dispensing record	5 years (Requirement of MHRA Guidance Note No. 14. Permanent record of batch details kept)	MHRA Guidance Note No. 14		N
Worksheets Raw material request and control forms	At least 5 years (Part of batch record, so product liability issues apply)			S
Resuscitation box	1 year after the expiry of the longest dated item	Applies only to repackaged items (e.g. ampoules separated from outer packaging)		S
Chemotherapy, aseptics worksheets, parenteral nutrition, production batch records	5 years (Product liability extends this to 11 years after expiry)	Product liability extends up to 11 years after expiry		S
Paediatric	At least 5 years See Note 6, Appendix ii)	Product liability extends up to 28 years		S
Quality Assurance Environmental monitoring results	1 year after expiry date of products As electronic record – in perpetuity			S
Equipment validation	Lifetime of the equipment			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Quality Control documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	Article 51(3) Directive 2001/83		S
Refrigerator temperature	1 year (Refrigerator records to be retained for the life of any product stored therein, particularly vaccines)			S
Standard operating procedures	15 years As electronic record – in perpetuity			S
Orders Invoices	6 years See Note 4, Appendix ii)	Limitation Act 1980		S
Order and delivery notes, requisition sheets, old order books	2 years Current financial year plus one See Note 4, Appendix ii)			S
Picking tickets/delivery notes	3 months (i.e. a "reasonable period" – for verification of order only)			S
Ward pharmacy requests	1 year (Record of what was requested by ward pharmacist – unlikely benefit after 12 months)	Limitation Act 1980		S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record) NB In the context of the Code of Practice a 'photograph' is a print taken with a camera and retained in the patient record.	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation Unless there is a clinical reason for retaining the digital image and a print is placed on the patient's record, there is no requirement to retain the digital image.		Destroy under confidential conditions	N
Physiotherapy records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Podiatry records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Post mortem records (see Pathology records)				
Post mortem registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	S
Prison healthcare records (see also GP records)	Where hospital letters for serving prisoners are scanned into the Prison Health computer system and the paper copy is also filed into the paper records the paper copy may be destroyed once it has been scanned into the system providing the scanning process and procedures are compliant with BSI's "BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically". Once the letters have been scanned they can be destroyed under confidential conditions.		Destroy under confidential conditions	C
Private patient records admitted under section 58 of the National Health Service Act 1977 or section 5 of the National Health Service Act 1946	Although technically exempt from the Public Records Acts, it would be appropriate for authorities to treat such records as if they were not so exempt and retain for period appropriate to the specialty		Destroy under confidential conditions	S
Psychology records	20 years or 8 years after death if patient died while in the care of the organisation		See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Psychotherapy Records	20 years or 8 years after the patient's death if patient died while in the care of the organisation	Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 NB "Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient's medical records or in a case-file……" These records are subject to the retention periods in this schedule	Destroy under confidential conditions	N
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Records of destruction of individual health records (case notes) and other health-related records contained in this retention schedule (in manual or computer format)	Permanently	BS ISO 15489 (section 9.10)	See note 1	S
Recovery Room Registers (Operating Theatre)	8 years	May have archival value. See note 1	Destroy under confidential conditions	N
Referral letters (for patients who are treated by the organisation to which they were referred)	Referral letters should be filed in the patient/client service user's health record, which contains the record of treatment and/or care received for the condition for which the referral was made. This will ensure that the patient record is a complete record. These records should then be retained for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Referral letters for clients referred to health or care services but not accepted.	Where there is a letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client, so the information is also held elsewhere. Retain for 2 years after the decision is made. Where there is no letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation. Referrals to the Clinical Assessment Service (who deal with our referrals to the therapy services), where the patient never followed up the initial referral from the G.P., and thus have no clinical or patient history with that service. Where the GP has been informed that the patient failed to attend and if all the information held in these files is non-clinical and is also held electronically on a computer system or held elsewhere the referrals can be destroyed.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Referral letters (to PCT clinical service e.g. ECG) where the results are sent back to GP's	2 years		Destroy under confidential conditions	N
Referral letters – where the appointment was cancelled by the patient before the referral letter was included in the patient record (i.e. before the clinic preparation process)	Where a letter is sent to the referring clinician detailing the reason(s) why the patient/client cancelled the appointment retain for 2 years after the date the appointment was cancelled. Where there is no letter or correspondence detailing the reasons for the patient not attending for their appointment that goes to the clinician that referred the patient/client. Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation.		Destroy under confidential conditions	N
Research Records 1. Clinical Trials of Investigational Medicinal Products (CTIMPs)				N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Trial Master File (responsibility of Sponsor & Chief Investigator to ensure that documents are retained)	Five years after the conclusion of the trial	The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006 – sections 18 and 28.	Destroy under confidential conditions	N
Research Ethics Committee Records	An ethics committee shall retain all the documents relating to a clinical trial on which it gives an opinion for: (a) where the trial proceeds, at least three years from the conclusion of the trial: or (b) where the trial does not proceed, at least three years from the date of the opinion.	Governance Arrangements for NHS Research Ethics Committees (GAfREC)	Destroy under confidential conditions	C
Trial Subject's Medical Files (Sponsor & Chief Investigator's responsibility to ensure retained)	Five years after the conclusion of the trial There should be a flag or divider in health records for documents pertaining to research indicating that the patient has been recruited to a clinical trial or other research		Destroy under confidential conditions	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Marketing authorisation (holders must arrange for essential clinical trial documents (including case report forms) other than subject's medical files, to be kept by the owners of the data):	15 yrs after completion or discontinuation of the trial, or Two years after the granting of the last marketing authorisation in the European Community and when there are no pending or contemplated marketing applications in the European Community, or two years after formal discontinuation of clinical development of the investigational product.	COMMISSION DIRECTIVE 2003/63/EC (brought into UK law by inclusion in The Medicines for Human Use (Fees and Miscellaneous Amendments) Regulations 2003) – section 5.2(c).	Destroy under confidential conditions	N
Trial subject's medical files	Retain in accordance with applicable legislation and in accordance with the maximum period of time permitted by the hospital, institution or private practice NB Documents can be retained for a longer period, however, if required by the applicable regulatory requirements or by agreement with the sponsor. It is the responsibility of the sponsor to inform the hospital, institution or practice as to when these documents no longer need to be retained.		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
All other documentation pertaining to the trial (retention of documentation is the responsibility of the sponsor or other owner of the data)	Retain as long as the product is authorised.		Destroy under confidential conditions	N
Final Report (responsibility of sponsor or subsequent owner's to retain documents)	Five years after the medicinal product is no longer authorised.		Destroy under confidential conditions	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
2. Data Collected in the Course of Research				
Data collected in the course of research	Retain for an appropriate period, to allow further analysis by the original or other research teams subject to consent, and to support monitoring by regulatory and other authorities.	Research Governance Framework for Health and Social Care – paragraph 2.3.5. Good Research Practice (MRC Ethics Series, 2000, updated 2005) – paragraph 5.2. Personal Information in Medical Research (MRC Ethics Series, 2000, updated 2003) – chapter 7. Data Protection Act 1998 – Part IV, Section 33 (3).	Destroy under confidential conditions	N
Risk Assessment Records	Retain the latest risk assessment until a new one replaces it.			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Scanned records relating to to patient care	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation. NB Providing the scanning process and procedures are compliant with BSI's BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically once the casenotes have been scanned the paper records can be destroyed under confidential conditions.		Destroy under confidential conditions	S
School health records (see Children and young people)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Sexual Health Records	10 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years	Destroy under confidential conditions	N
Smoking Cessation Records	2 years unless there are clinical indications to keep them for longer NB PCT's should consider whether they need to retain these records for a longer period if any medication etc is dispensed.		Destroy under confidential conditions	N
Speech and language therapy records	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Suicide – notes of patients having committed suicide	10 years		See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Temporary Resident's Forms (GMS 3/99)	2 years NB Temporary GPs should maintain a record of episodes of treatment and diagnoses as well as sending a copy to the patient's normal GP		Destroy under confidential conditions	N
Transplantation records	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 30 years	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) Addendum 1	See note 1	C
Ultrasound records (eg vascular, obstetric)	Retain for the period of time appropriate to the patient/ specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Vaccination records (see Immunisation and vaccination records)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Video records/voice recordings relating to patient care/ video records/video-conferencing records related to patient care/DVD records related to patient care Includes: Telemedicine records Out of hours records (GP cover) NHS Direct records	8 years subject to the following exceptions or where there is a specific statutory obligation to retain records for longer periods: **Children and young people**: Records must be kept until the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday, or until 8 years after the patient's death if sooner **Maternity**: 25 years **Mentally disordered persons**: Records should be kept for 20 years after the date of last contact between patient/client/service user and any healthcare professional or 8 years after the patient's death if sooner **Cancer patients**: Records should be kept until 8 years after the conclusion of treatment, especially if surgery was involved. The Royal College of Radiologists has recommended that such records be kept permanently where chemotherapy and/or radiotherapy was given	Guidance on use of video-conferencing in healthcare: http://www.wales.nhs.uk/sites/documents/351/1_multipart_xF8FF_3_Guidance%20on%20the%20Use%20of%20Videoconferencing%20in%20Healthcare%20Ve_.pdf	The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. Video/ video-conferencing records should be either permanently archived or permanently destroyed by shredding or incineration (having due regard to the need to maintain patient confidentiality).	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Vulnerable Adults (records for)	Where a patient/client/service user is transferred from the care of one NHS or social care organisation to another, all relevant information must be transferred to the patients' health or social care record held at the receiving organisation and they should then be retained for the period of time appropriate to the specialty. Where a patient/client/service user is assessed by a health or social care professional including ambulance personnel and is identified as a vulnerable adult the professional should follow the protocols for dealing with vulnerable adults in their organisation.		Destroy under confidential conditions	N
Ward registers, including daily bed returns (where they exist in paper format)	2 years after the year to which they relate		Likely to have archival value. See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
X-ray films (including other image formats for all imaging modalities/diagnostics)	General Patient Records – 8 years after conclusion of treatment Children & Young People – Until the patient's 25th birthday, or if the patient was 17 at conclusion of treatment, until their 26th birthyday or 8 years after the patient's death if sooner. Maternity – 25 years after the birth of the child, including still births Clinical Trials – 15 years after completion of treatment Litigation – Records should be reviewed 10 years after the file is closed. Once litigation has been notified (or a formal complaint received) images should be stored until 10 years after the file has been closed. Mental Health – 20 years after no further treatment considered necessary or 8 years after death. Oncology – see Oncology Records	BFCR(06)4 – Royal College of Radiologists Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
X-Ray Referral/ Request Cards	8 years providing there is a record in the patient's health record that a referral/ request was made for an x-ray	Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234	Destroy under confidential conditions	N
X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
X-ray reports (including reports for all imaging modalities)	To be considered as a permanent part of the patient record and should be retained for the appropriate period of time			S

APPENDIX C : PRINCIPLES TO BE USED IN DETERMINING POLICY REGARDING THE RETENTION AND STORAGE OF ESSENTIAL MATERNITY RECORDS

British Paediatric Association
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Joint Position on the Retention of Maternity Records

1. All essential maternity records should be retained. 'Essential' maternity records mean those records relating to the care of a mother and baby during pregnancy, labour and the puerperium.

2. Records that should be retained are those which will, or may, be necessary for further professional use. 'Professional use' means necessary to the care to be given to the woman during her reproductive life, and/or her baby, or necessary for any investigation that may ensue under the Congenital Disabilities (Civil Liabilities) Act 1976, or any other litigation related to the care of the woman and/or her baby.

3. Local level decision making with administrators on behalf of the health authority must include proper professional representation when agreeing policy about essential maternity records. 'Proper professional' in this context should mean a senior medical practitioner(s) concerned in the direct clinical provision of maternity and neonatal services and a senior practising midwife.

4. Local policy should clearly specify particular records to be retained AND include detail regarding transfer of records, and needs for the final collation of the records for storage. For example, the necessity for inclusion of community midwifery records.

5. Policy should also determine details of the mechanisms for return and collation for storage, of those records which are held by mothers themselves, during pregnancy and the puerperium.

List of Maternity Records to be Retained

6. Maternity Records retained should include the following:
    1. documents recording booking data and pre-pregnancy records where appropriate;

    2. documentation recording subsequent antenatal visits and examinations;

    3. antenatal in-patient records;

    4. clinical test results including ultrasonic scans, alpha-feto protein and chorionic villus sampling;

    5. blood test reports;

    6. all intrapartum records to include, initial assessment, partograph and associated records including cardiotocographs;

    7. drug prescription and administration records;

    8. postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.

APPENDIX D : BUSINESS AND CORPORATE (NON-HEALTH) RECORDS RETENTION SCHEDULE

This retention schedule details a Minimum Retention Period for each type of non- health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. The National Archives (see Note 1 below) should be consulted where a longer period than 30 years is required, or for any pre-1948 records. Organisations should also remember that records containing personal information are subject to the Data Protection Act 1998.

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound):

- administrative records (including personnel, estates, financial and accounting
- records, and notes associated with complaint handling);
- photographs, slides and other images (non-clinical);
- microform (ie microfiche/microfilm);
- audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents

The schedule is split into the following types of records:

Administrative (corporate and organisation)
Biomedical Engineering
Estates/engineering
Financial
IM & T
Other
Personnel/human resources
Purchasing/supplies

If viewed in electronic format, the search facility in Word or PDF can be used to search for particular record types.

Notes

An organisation with an existing relationship with an approved Place of Deposit should consult the Place of Deposit in the first instance. Where there is no pre- existing relationship with a Place of Deposit, organisations should consult The National Archives.

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
ADMINISTRATIVE (CORPORATE AND ORGANISATION)				
Accident forms (see also Litigation dossiers)	10 years		Destroy under confidential conditions	S
Accident register (Reporting of Injuries,Diseases and Dangerous Occurrencesregister) – see also Incident forms	10 years	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (reg. 7); SocialSecurity (Claims and Payments) Regulations (reg. 25)	Destroy under confidential conditions	C
Adoption records (i.e. administrative records relating the adoption process)	75th anniversary of the date of birth of the child to whom it relates or, if the child dies before attaining the age of 18,15 years beginning with thedate of the 18th birthday	Children and Young Persons Arrangements for Placement of Children (General) (Regulations 1991,SI 1991, No. 890 regs. 8, 9, 10 – children's records) Adoption Regulations 2004(reg. 34)	Destroy under confidential conditions	N
Advance letters (eg DH guidance)	6 years		Destroy	S
Agendas of board meetings, committees, sub-committees (master copies,including associated papers)	30 years		See note 1	S
Agendas (other)	2 years		Destroy under confidential conditions	S
Agreements (see Contracts)				

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Ambulance Records – Administrative (i.e. records containing non-clinical details only) e.g. records of journeys	2 years from the end of the year to which they relate		Destroy under confidential conditions	N
Annual/corporate reports	3 years		See note 1	S
Appointment Records (GP)	2 years (Provided that any patient-relevant information has been transferred to the patient record) At the end of the 2 year retention period GP practices should consider if there is an ongoing administrative need to keep the records/books for longer. If there IS an ongoing need to retain these records/books, then a further review date should be set (either 1 or 2 more years)		Destroy under confidential conditions – once a decision has been made that there is no ongoing administrative need to retain the records.	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Assembly/Parliamentary questions,MP enquiries	10 years		As these documents include all information provided by the organisation in response to a PQ (e.g. background note to the Minister or the Minster may amend the response) all of which may not be used in the response and therefore it will not be in the public domain on House of Commons records they must be destroyed under confidential conditions.	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Audit Records (e.g. Organisational Audits, Records Audits, Systems Audits) – Internal & External in any format (paper, electronic etc)	2 years from the date of completion of the audit		Destroy under confidential conditions	N
Business plans, including local delivery plans	20 years		Destroy	S
Catering forms	6 years		Destroy under confidential conditions	S
Close circuit TV images	31 days	Information Commissioner's Code of Conduct	Erase permanently	S
Commissioning decisions – Appeal documentation – Decision documentation	 – 6 years from date of appeal decision – 6 years from date of decision		Destroy under confidential conditions	S S
Complaints (See also litigation dossiers) – Correspondence, investigation and outcomes – Returns made to DH	 – 8 years from completion of action – Files closed annually and kept for 6 years following closure NB: Current policy on the handling of complaints is under review and further guidancewill be issued in due course		Destroy under confidential conditions	C
Copyright declaration forms (Library Service)	6 years	Copyright, Designs and Patents Act 1988	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Data Input Forms (where the data/ information has been input to a computer system)	2 years		Destroy under confidential conditions	N
Diaries (office)	1 year after the end of the calendar year to which they refer		Destroy under confidential conditions	S
Exposure monitoring records	5 years from the date the record was made	Control of Substances Hazardous to Health Regulations 2002 (reg. 10(5))	Destroy under confidential conditions	S
'Find-a-Doc' records (kept by PCT's) – contact sheets and letters – assignment cases/letters – records of negotiations with GMS contract managers re: patient registration with a GP	 6 months 2 years 2 years		Destroy under confidential conditions	N
Flexi working hours (personal record of hours actually worked)	6 months		Destroy under confidential conditions	S
Freedom of Information requests	3 years after full disclosure; 10 years if information is redacted or the information requested is not disclosed		Destroy under confidential conditions	S
GMS1 forms (registration with GP)	3 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Health and safety documentation	3 years		Destroy under confidential conditions	S
History of organisation or predecessors, its organisation and procedures (eg establishment order)	30 years		See note 1	S
Hospital (trust) services i.e. service that the Trust provides e.g. catering, hotel services	10 years		Destroy	S
Incident forms	10 years		Destroy under confidential conditions	C
Indices (records management)	Registry lists of public records marked for permanent preservation, or containing the record of management of public records – 30 years File lists and document lists where public records or their management are not covered – 30 years		See note 1 Destroy under confidential conditions	S S
Laundry lists and receipts	2 years from completion of audit		Destroy under confidential conditions	S
Library registration forms	2 years after registration		Destroy	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Litigation dossiers (complaints including accident/incident reports) Records/documents relating to anyform of litigation	10 years Where a legal action has commenced, keep as advised by legal representatives		Destroy under confidential conditions	S S
Manuals – policy and procedure (administrative and clinical, strategy documents)	10 years after life of the system (or superseded) to which the policies or procedures refer		Destroy (policy documents may have archival value – see note 1)	S
Maps	Lifetime of the organisation		See note 1	S
Meetings and minutes papers of major committees and sub-committees (master copies)	30 years		See note 1	S
Meetings and minutes papers (other, including reference copies of major committees)	2 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Mental Health Act Administration Records	5 years NB There is no obligation to treat this type of mental health record as being part of a patient's health record. There may, however, be exceptions, such as where they are required to be kept as evidence in actual or expected litigation or where they are needed by a healthcare professional in order to provide healthcare. Each healthcare practitioner has discretion as to the information which s/he wishes to include as part of a patient record. If in any particular case a healthcare practitioner requires a document which forms part of the mental health act administration record to be included in a patient's record (because he or she regards it as relevant to the patient's healthcare), it should then be regarded as part of the patient' health record	HC(91)29 (NHS) SI 2001/3869, reg.47 (Independent Sector)	Destroy under confidential conditions	N
Mortgage documents (acquisition, transfer and disposal)	6 years after repayment		See note 1	S
Nominal rolls	6 years (maximum)		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Papers of minor or short-lived importance not covered elsewhere, eg: – advertising matter – covering letters – reminders – letters making appointments – anonymous or unintelligible letters – drafts – duplicates of documents known to be preserved elsewhere (unless they have important minutes on them) – indices and registers compiled for temporary purposes – routine reports – punched cards – other documents that have ceased to be of value on settlement of the matter involved	2 years after the settlement of the matter to which they relate		Destroy under confidential conditions	S
Patient Advice & Liaison Service (PALS) records	10 years after closure of the case		Destroy under confidential conditions	N
Patient information leaflets	6 years after the leaflet has been superseded		See note 1	C

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Patients' property books/registers (property handed in for safekeeping)	6 years after the end of the financial year in which the property was disposed of or 6 years after the register was closed		Destroy under confidential conditions	S
Patient Surveys (re access to services etc)	2 years		Destroy under confidential conditions	N
Phone Message Books	2 years NB Any clinical information should be transferred to the patient health record		Destroy under confidential conditions	N
Police Statements (made in the context of Accident and Emergency episodes. Statements are requested by the Police to the A&E staff in relation to alleged injuries of or by patients coming through A&E)	10 years (congruent retention period as Incident Forms)		Destroy under confidential conditions	N
Press cuttings	1 year		Destroy (where bound volumes exist, see note 1)	S
Press Releases	7 years		see note 1	N
Project files (over £100,000) on termination, including abandoned or deferred projects	6 years		See note 1	S
Project files (less than £100,000) on termination	2 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Project team files (summary retained)	3 years		Destroy under confidential conditions	S
Public Consultations e.g. about future provision of services	5 years		Destroy under confidential conditions	N
Quality and Outcomes Framework (QOF) documents (GP Practice records)	2 years		Destroy under confidential conditions	N
Quality assurance records (eg Healthcare Commission, Audit Commission, King's Fund Organisational Audit, Investors in People)	12 years		Destroy under confidential conditions	S
Receipts for registered and recorded mail	2 years following the end of the financial year to which they relate		Destroy under confidential conditions	S
Records documenting the archiving, transfer to public records archive or destruction of records	30 years		See note 1	S
Records of custody and transfer of keys	2 years after last entry		Destroy under confidential conditions	S
Reports (major)	30 years		See note 1	S
Requests for access to records, other than Freedom of Information or subject access requests	6 years after last action		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Requisitions	18 months		Destroy under confidential conditions	S
Research ethics committee records	3 years from date of decision		See note 1	C
Serious incident files	30 years		See note 1	S
Specifications (eg equipment, services)	6 years	Limitation Act 1980	Destroy under confidential conditions	S
Statistics (including Korner returns, contract minimum data set, statistical returns to DH, patient activity)	3 years from date of submission		Destroy	S
Subject access requests (DPA and AHR)– records of requests	3 years after last action		Destroy under confidential conditions	S
Surgical appliances forms AP 1, 2, 3 and 4	2 years from completion of audit		Destroy under confidential conditions	S
Time sheets (relating to a Group or Department e.g. Ward where the timesheets are kept as a tool to manage resources, staffing levels)	6 months		Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
BIOMEDICAL ENGINEERING				
Sterilix Endoscopic Disinfector Daily Water Cycle Test,	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	N
Sterilix Endoscopic Disinfector Daily Water Purge Test, Nynhydrin Test	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
ESTATES/ENGINEERING				
Buildings and engineering works, including major projects abandoned or deferred – key records (eg final accounts, surveys, site plans, bills of quantities)	30 years		See note 1	S
Buildings and engineering works, including major projects abandoned or deferred – town and country planning matters and all formal contract documents (eg executed agreements, conditions of contract, specifications, 'as built' record drawings, documents on the appointment and conditions of engagement of private buildings and engineering consultants)	30 years		See note 1	S
Buildings – papers relating to occupation of the building (but not health and safety information)	3 years after occupation ceases	Construction Design Management Regulations 1994	Destroy under confidential conditions	S
Deeds of title	Retain while the organisation has ownership of the building unless a Land Registry certificate has been issued, in which case the deeds should be placed in an archive If there is no Land Registry certificate, the deeds should pass on with the sale of the building		See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Drawings – plans and buildings (architect signed, not copies)	Lifetime of the building to which they relate		See note 1	S
Engineering works – plans and building records	Lifetime of the building to which they relate		See note 1	S
Equipment – records of non-fixed equipment, including specification, test records, maintenance records and logs	11 years If the records relate to vehicles (ambulances, responder cars, fleet vehicles etc) and where the vehicle no longer exists, providing there is a record that it was scrapped, the records can be destroyed	Consumer Protection Act 1987	Destroy under confidential conditions	N
Inspection reports (eg boilers, lifts)	Lifetime of installation If there is any measurable risk of a liability in respect of installations beyond their operational lives, the records should be retained indefinitely		See note 1	S
Inventories of furniture, medical and surgical equipment not held on store charge and with a minimum life of 5 years	Keep until next inventory		See note 1	C
Inventories of plant and permanent or fixed equipment	5 years after date of inventory		See note 1	S
Land surveys/registers	30 years		See note 1	S
Leases – the grant of leases, licences and other rights over property	Period of the lease plus 12 years	Limitation Act 1980	Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Maintenance contracts (routine)	6 years from end of contract		Destroy under confidential conditions	S
Manuals (operating)	Lifetime of equipment		Review if issues (eg HSE) are outstanding	S
Medical device alerts	Retain until updated or withdrawn (check MHRA website)	www.mhra.gov.uk	Destroy under confidential conditions	S
Photographs of buildings	30 years		See note 1	S
Plans – building (as built)	Lifetime of building		May have historical value – see note 1	S
Plans – building (detailed)	Lifetime of building		May have historical value (see note 1)	S
Plans – engineering	Lifetime of building		See note 1	S
Property acquisitions dossiers	30 years		See note 1	S
Property disposal dossiers	30 years		See note 1	S
Radioactive waste	30 years	Radioactive Substances Act 1993	See note 1	S
Site files	Lifetime of site		See note 1	S
Structure plans (organisational charts) i.e. the structure of the building plans	Lifetime of building		See note 1	C
Surveys – building and engineering works	Lifetime of building or installation		See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
FINANCIAL				
Accounts – annual (final – one set only)	30 years		See note 1	S
Accounts – minor records (pass books, paying-in slips, cheque counterfoils, cancelled/ discharged cheques (for cheques bearing printed receipts, see Receipts), accounts of petty cash expenditure, travel and subsistence accounts, minor vouchers, duplicate receipt books, income records, laundry lists and receipts)	2 years from completion of audit		Destroy under confidential conditions	S
Accounts – working papers	3 years from completion of audit		Destroy under confidential conditions	S
Advice notes (payment)	1.5 years		Destroy under confidential conditions	S
Audit records (internal and external audit) – original documents	2 years from completion of audit		Destroy under confidential conditions	N
Audit reports – internal and external (including management letters, value for money reports and system/final accounts memoranda)	2 years after formal completion by statutory auditor		Destroy under confidential conditions	N
Bank statements	2 years from completion of audit		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Banks Automated Clearing System (BACS) records	6 years after year end		Destroy under confidential conditions	S
Benefactions (records of)	5 years after end of financial year in which the trust monies become finally spent or the gift in kind is accepted. In cases where the Benefaction Endowment Trust fund/capital/ interest remains permanent,records should be permanently retained by the organisation		See note 1	S
Bills, receipts and cleared cheques	6 years		Destroy under confidential conditions	S
Budgets (including working papers, reports, virements and journals)	2 years from completion of audit		Destroy under confidential conditions	S
Capital charges data	2 years from completion of audit		Destroy under confidential conditions	S
Capital paid invoices (see Invoices)				
Cash books	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Cash sheets	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Contracts – financial	Approval files – 15 years Approved suppliers lists – 11 years		Destroy under confidential conditions	C
Contracts – non-sealed (property) on termination	6 years after termination of contract	Limitation Act 1980	Destroy under confidential conditions	S
Contracts – non-sealed (other) on termination	6 years after termination of contract	LimitationAct 1980	Destroy under confidential conditions	S
Contracts – sealed (and associated records)	Minimum of 15 years, after which they should be reviewed		See note 1	S
Contractual arrangements with hospitals or other bodies outside the NHS, including papers relating to financial settlements made under the contract (eg waiting list initiative, private finance initiative)	6 years after end of financial year to which they relate		Destroy under confidential conditions	S
Cost accounts	3 years after end of financial year to which they relate		Destroy under confidential conditions	S
Creditor payments	3 years after end of financial year to which they relate		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Debtors' records – cleared	2 years from completion of audit		Destroy under confidential conditions	S
Debtors' records – uncleared	6 years from completion of audit		Destroy under confidential conditions	S
Demand notes	6 years after end of financial year to which they relate		Destroy under confidential conditions	S
Estimates, including supporting calculations and statistics	3 years after end of financial year to which they relate		Destroy under confidential conditions	S
Excess fares	2 years after end of financial year to which they relate		Destroy under confidential conditions	S
Expense claims, including travel and subsistence claims, and claims and authorisations	5 years after end of financial year to which they relate		Destroy under confidential conditions	S
Fraud case files/investigations	6 years		Destroy under confidential conditions	S
Fraud national proactive exercises	3 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Funding data	6 years after end of financial year to which they relate		Destroy under confidential conditions	S
General Medical Services payments	6 years after year end		Destroy under confidential conditions	S
Invoices	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Ledgers, including cash books, ledgers, income and expenditure journals, nominal rolls, non-exchequer funds records (patient monies)	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Non-exchequer funds records (i.e. funding received by the organisation that does not directly relate to patient care eg charitable funds)	30 years Company charities are required by company law to keep their accounts and accounting records for at least three years but the Charity Commission recommends that they be kept for at least 6 years. The majority of non-company charities must keep their accounts and accounting records for six years (Part VI Charities Act 1993).		Although technically exempt from the Public Records Act, it would be appropriate for authorities to treat these records as if they were not exempt	N
Patient Monies (i.e. smaller sums of donated money)	6 years		Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
PAYE records	6 years after termination of employment		Destroy under confidential conditions	S
Payments	6 years after year end		Destroy under confidential conditions	S
Payroll (ie list of staff in the pay of the organisation)	6 years after termination of employment		Destroy under confidential conditions For superannuation purposes, organisations may wish to retain such records until the subject reaches benefit age	S
Positive predictive value performance indicators	3 years		Destroy under confidential conditions	S
Private Finance Initiative (PFI)	30 years		See note 1	S
Receipts	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Salaries (see Wages)				

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Superannuation accounts	10 years		Destroy under confidential conditions	S
Superannuation registers	10 years		Destroy under confidential conditions	S
Tax forms	6 years		Destroy under confidential conditions	S
Transport (staff pool car documentation)	3 years unless litigation ensues		Destroy under confidential conditions	S
Trust documents without permanent relevance/not otherwise mentioned	6 years		Destroy under confidential conditions	S
Trusts administered by Strategic HealthAuthorities (terms of)	30 years		See note 1	S
VAT records	6 years after end of financial year to which they relate		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Wages/salary records	10 years after termination of employment		Destroy under confidential conditions For superannuation purposes, organisations may wish to retain such records until the subject reaches benefit age.	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
IM & T				
Documentation relating to computer programmes written in-house	Lifetime of software		Destroy under confidential conditions	S
Software licences	Lifetime of software		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
OTHER				
Chaplaincy records	2 years		May have archival value – see note 1	S
Contractor Applications (Doctors, Dentists, Opticians & Pharmacists)	6 years after end of contract for approvals 6 years for non-approvals.		Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Contractor Records (e.g. Ophthalmic Opticians, Ophthalmic Medical Practitioners, Pharmacists, Pharmacy Premises, General Optical Council amendments to the register, Previous Pharmacy rotas and supporting information (prior to 2005 – new regulations), Copies of previous Pharmacy and Ophthalmic local lists, Correspondence relating to pharmacies supplying oxygen and visiting Residential/ Nursing homes (prior to new regulations)	7 years	NHS(General Ophthalmic Services) Regs 1986: A contractor shall keep a proper record in respect of each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing. Subject to paragraph 8(5) a contractor shall retain all such records for a period of seven years, and shall during that period produce them when required to do so by a Primary Care Trust or the Secretary of State. Follow link below for more detail http://www.dh.gov.uk/assetRoot/04/10/12/42/04101242.pdf	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Doctors Postgraduate Educational Allowance/ Personal Development Plan files and supporting general correspondence – Records kept by PCT's	GP Seniority (prior to 2004 – new regulations)	NHS(General Ophthalmic Services) Regs 1986: A contractor shall keep a proper record in respect of each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing. Subject to paragraph 8(5) a contractor shall retain all such records for a period of seven years, and shall during that period produce them when required to do so by a Primary Care Trust or the Secretary of State. Follow link below for more detail http://www.dh.gov.uk/assetRoot/04/10/12/42/04101242.pdf	Destroy under confidential conditions	N
Family Health Service Appeals Authority tribunal and case files	Case files – 10 years Decision records – until individual's 80th birthday		See note 1 Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
GP retirements/moved away	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday		See note 1	N
Research and development (organisation) i.e. all the organisation's records associated with research and development and not individual trial records or information on patients.	30 years	Medical Research Council	See note 1	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
PERSONNEL/HUMAN RESOURCES				
NB Both medical staff records and agency locums staff records should be treated as personnel records and retained accordingly.				
Consultants (records relating to the recruitment of)	5 years	NHS (Appointment of Consultants) Regulations, good practice guidelines, page 11, para. 5.3 http://www.dh.gov.uk/assetRoot/04/10/27/50/04102750.pdf	Destroy under confidential conditions	S
CVs for non-executive directors (successful applicants)	5 years following term of office		Destroy under confidential conditions	S
CVs for non-executive directors (unsuccessful applicants)	2 years		Destroy under confidential conditions	S
Duty rosters i.e. organisation or departmental rosters, not the ones held on the individual's record.	4 years after the year to which they relate		Destroy under confidential conditions	N
Industrial relations (not routine staff matters), including industrial tribunals	10 years		Destroy under confidential conditions	S
Job advertisements	1 year		Destroy	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Job applications (successful)	3 years following termination of employment		Destroy under confidential conditions	S
Job applications (unsuccessful)	1 year		Destroy under confidential conditions	S
Job descriptions	3 years		Destroy under confidential conditions	S
Leavers' dossiers	6 years after individual has left Summary to be retained until individual's 70th birthday or until 6 years after cessation of employment if aged over 70 years at the time. The summary should contain everything except attendance books, annual leave records, duty rosters, clock cards, timesheets, study leave applications, training plans	The 6 year retention period is to take into account any ET claims, or EL claims that may arise after the employee leaves NHS employment, requests for information from the NHS pensions agency etc. Claims of this nature can include periods of up to 6 years or more prior to the claim and where evidence could be needed from a number of sources, it is appropriate to retain as much as possible from the original file.	Destroy under confidtial conditions See note 1	N
Letters of appointment	6 years after employment has terminated or until 70th birthday, whichever is later		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Nurse training records (from hospital-based nurse training schools prior to the introduction of academic-based training)	30 years		See note 1	N
Pension Forms (all)	7 years	HMRC Technical Pension Notes for registered pension schemes under regulation 18 of SI2006/567 – 'RPSM12300020 – Scheme Adminstrator Information Requirements and Adminstration for General Retention of Records'	Destroy under confidential conditions	N
Personnel/human resources records –major (eg personal files, letters of appointment, contracts, references and related correspondence, registration authority forms, training records, equal opportunity monitoring forms (if retained)) NB Includes locum doctors	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday Summary to be retained until individual's 70th birthday or until 6 years after cessation of employment if aged over 70 years at the time. The summary should contain everything except attendance books, annual leave records, duty rosters, clock cards, timesheets, study leave applications, training plans	The 6 year retention period is to take into account any ET claims, or EL claims that may arise after the employee leaves NHS employment, requests for information from the NHS pensions agency etc. Claims of this nature can include periods of up to 6 years or more prior to the claim and where evidence could be needed from a number of sources, it is appropriate to retain as much as possible from the original file.	See note 1	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Personnel/human resources records – minor (eg attendance books, annual leave records, duty rosters (i.e. duty rosters held on the individual's record not the organisation or departmental rosters), clock cards, timesheets (relating to individual staff members)) NB Includes locum doctors	2 years after the year to which they relate		Destroy under confidential conditions	N
Staff car parking permits	3 years		Destroy under confidential conditions	S
Study leave applications	5 years		Destroy under confidential conditions	S
Timesheets (for individual members of staff)	2 years after the year to which they relate NB Timesheets (for all individuals including locum doctors) held on the personnel record are minor records – retain for 2 years. Timesheets held elsewhere – i.e. on the ward retain for 6 months (as the master timesheet is held on the personnel file)		Destroy under confidential conditions	N
Training plans	2 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
PURCHASING/SUPPLIES				
Approval files (contracts)	6 years after end of the year the contract expired		Destroy under confidential conditions	S
Approved suppliers lists	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	S
Delivery notes	2 years after end of financial year to which they relate		Destroy under confidential conditions	S
Products (liability)	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	S
Stock control reports	18 months		Destroy under confidential conditions	S
Stores records – major (eg stores ledgers)	6 years		Destroy under confidential conditions	S
Stores records – minor (eg requisitions, issue notes, transfer vouchers, goods received books)	18 months		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Supplies records – minor (eg invitations to tender and inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery and other supplies)	18 months		Destroy under confidential conditions	S
Tenders (successful)	Tender period plus 6 year limitation period	Limitation Act 1980	Destroy under confidential conditions	S
Tenders (unsuccessful)	6 years	Limitation Act 1980	Destroy under confidential conditions	S

APPENDIX E : ELECTRONIC RECORD/ AUDIT TRAILS

1. Electronic records are supported by audit trails, which record details of all additions, changes, deletions and viewings. Typically, the audit trail will include information on:

    - who - identification of the person creating, changing or viewing the record;
    - what - details of the data entry or what was viewed;
    - when - date and time of the data entry or viewing; and
    - where - the location where the data entry or viewing occurred.

2. Audit trails are important for medico-legal purposes as they enable the reconstruction of records at a point in time. Without its associated audit trail, there is no reliable way of confirming that an entry is a true record of an event or intervention.

3. NHS Connecting for Health is considering the impact of the retention of audit trail data, eg whether it should be retained for at least the same period as the data to which it relates. There is also an unresolved issue regarding the association of audit trail data with electronic GP records transferred between practices.

4. Advice and guidance specific to audit trails will be issued in due course on the Department of Health website (http://www.dh.gov.uk/ PolicyandGuidance/OrganisationPolicy/RecordsManagement/). In the meantime, NHS organisations are advised to retain all audit trails until further notice.

APPENDIX F : APPROVED PLACES OF DEPOSIT

'Where an NHS Trust has previously deposited records with a given place of deposit listed here, it should continue to /liaise with the same institution unless it receives guidance from The National Archives (TNA) to the contrary. If a Trust is not aware of any previous transfers, or as a result of re-organisation has previously transferred records to more than one place of deposit, it should contact National Advisory Services at TNA (nas@nationalarchives.gov.uk, tel 020 8392 5330 x2620), who will be able to advise which place of deposit should be contacted regarding further transfers. National Advisory Services will also be happy to advise on any other queries regarding the working of the Public Records Act in respect of NHS records.'

A list of all the current appointed Places of Deposit is available on The National Archives website (see below)
http://www.nationalarchives.gov.uk/archives/deposit.htm

The current contact details of these institutions are on The National Archives Archon Directory page (see below)
http://www.nationalarchives.gov.uk/archon/

APPENDIX H:

EQUALITY IMPACT ASSESSMENT TOOL

RECORDS MANAGEMENT POLICY

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	NO	For each category describe how you have involved stakeholders including service users and employees
	Race and Ethnic origin (include gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	NO	
	Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	NO	
	Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	NO	
	Culture (consider dietary requirements and individual care needs)	NO	
	Religion or belief (include dress, individual care needs and	NO	

		Yes/No	Comments
	spiritual needs for consideration)		
	Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs	NO	
	Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist)	NO	
2.	**Is there any evidence that some groups are affected differently?**	NO	
3.	**If you have identified potential discrimination, for example, less than equal access, are any exceptions valid, legal and/or justifiable, for example a genuine occupational qualification?**	NO	
4.	**Is the impact of the policy/guidance likely to be negative?**	NO	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this policy, please refer it to the appropriate Action Group, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Maria Crosbie, HR Manager, on extension 2552.