Schedule	NHS Worcestershire Acute Hospitals NHS Trust

Corporate Records Retention and Disposal Schedule Appendix 12

Please see Corporate Records Management Policy for further information

Department / Service:	Corporate
Originator:	Information Governance Manager
Accountable Director:	Director of Finance (SIRO)
Approved by:	Information Governance Steering Group (IGSG) Key Documents Approval Group (KDAG)
Date of approval:	Appendix 12 of Corporate Records Management Policy
First Revision Due:	National update to NHS records
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All

Schedule Overview:
This document is appendix 12 of the Corporate Records Management Policy and Procedure

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Section 4: Retention Schedule

Note on Public Records Act 1958

Retention periods given in this schedule are those for operational purposes. Selection for transfer under the Public Records Act 1958 (referred to in this section as the Act) is a separate process designed to ensure the permanent preservation of a small core (typically 2-5%) of key records which will:

- Enable the public to understand the working of the organisation and its impact on the population it serves and
- Preserve information and evidence likely to have long-term research value.

PoDs have a good working knowledge of the use made of records after transfer and will be able to provide more detailed advice to supplement the guidance in this Code.

Selection may take place at any time in advance of transfer and in the case of digital records, preferably at or before the point at which they are created. Records may be selected as a class (for example all board minutes) or at lower levels down to individual files or items. Where it is known a record will form part of the public record at creation, it must be preserved locally until such time it can be transferred. The retention periods must be applied at creation and not as part of a reactive process such as organisational change. Older records that may still be in the possession of organisation may need to be reviewed and reappraised in the light of the more explicit recommendations for retention of records for the public record in this Code.

Records must be selected in accordance with the guidance contained in this Code, and any supplementary guidance issued by TNA or local guidance from the relevant PoD, which should always be consulted in advance:

- 'Transfer to PoD' - this class of records should normally transfer in its entirety to the PoD (trivial or duplicate items may be excepted)
- 'Possible transfer to PoD' - all, some or none of this class may be selected as agreed with the PoD
- Other records should not normally be selected for transfer

If this includes a decision not to select a class listed for transfer, or to select records not listed for transfer, the reason should be published in the records management policy or equivalent.

Records of individual persons may be selected and transferred if the PoD agrees, provided this is necessary and proportionate in relation to the broadly historical purposes of the Public Records Act 1958. Historically about 20% of NHS organisations have selected some individual patient records.

The Public Records Act 1958 is not designed to support the current operational research activities of the NHS and records should not be selected if that is the only or primary purpose in doing so. As patient confidentiality will normally prevent use for many decades after transfer and the resource involved will be substantial, it should only be considered where one or more of the factors listed below apply and for a sample or sub-set of records[82]. Any records selected should normally be retained within the NHS (under the

[82] For possible approaches to this see:

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terms of Retention Instrument 122, which applies to individual patient records in general) until the patient is known, or can be assumed to be deceased. This is so that they continue to be readily available to support further medical care if necessary.

Any policy to select patient records should only be agreed after consultation with appropriate clinicians, including the Caldicott Guardian and research lead. This decision and the reasoning behind it should be published in the records management policy of the organisation or its equivalent. Any objections by patients to the selection of their individual patient record should be respected.

The following factors should be taken into account when considering selection of patient records:

- The organisation has an unusually long or complete run of records of a given type
- The records relate to population or environmental factors peculiar to the locality
- The records are likely to support research into rare or long-term conditions
- The records relate to an event or issue of significant local or national importance (for example a public inquiry or a major incident)
- The records relate to the development of new or unusual treatments or approaches to care and/or the organisation is recognised as a national or international leader in the field of medicine concerned
- The records throw particular light on the functioning, or failure, of the organisation, or the NHS in general
- The records relate to a significant piece of published research

Retention of records in the digital age can be problematic. This is because of a number of factors inherent to electronic record keeping. The fragility of software and the equipment it runs on means that long term retention of digital information is very difficult.

Good Practice about blanket retention rules:

Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) as a mental health and community provider has now agreed to retain all discharged adult patient files for a minimum of 20 years, where there is a possibility that patients may have a dual diagnosis one of which may be related to mental health.

The retention of information for the purpose of direct care of a patient will never be questioned and the ability of electronic care systems to store information means that the potential of 'whole care records' may be possible for the life of a patient across all care sectors.

The retention periods listed in this retention schedule must always be considered minimum.

For more information, see R v Northumberland County Council and the Information Commissioner (23 July 2015)[83]. This provides assurance that it is legitimate to vary common practice/guidance where a well-reasoned case for doing so is made.

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http://www.healtharchives.org/docs/hospital_case_records_2006_final_version.pdf
[83] http://www.bailii.org/ew/cases/EWHC/Admin/2015/2134.html

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Clinical records are problematic to preserve permanently in an archive or by the organisations that created them. Following appraisal, medical records or a series of records, may be worthy of permanent preservation for reasons other than care, usually as part of a portfolio of clinical work. Section 33 of the DPA is often quoted as the basis for preservation. An application of the Section 33 exemption must have regard for the patient's wishes where they have been indicated, which respects the duty of confidence as this is a limited exemption which only provides exemption from DPA Principles 2 and 5 and some subject access requests.

Good Practice at The National Archives:

Some of the allegations relating to abuse by Jimmy Savile at NHS sites dated back to 1954 and in many cases, investigators reported great difficulty in tracing records or witnesses over such a long period of time.

With the exception of visitor books, all the types of records found useful by investigation teams were core records listed in the 2006 NHS Records Management Code of Practice as appropriate for potential selection and transfer to places of deposit appointed under the Public Records Act 1958.

In 16 out of 39 cases, investigators referred to transferred material and where significant transfers had been implemented in accordance with the Act, such as at South London and Maudsley NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, Nottinghamshire Healthcare NHS Trust or Leeds Teaching Hospitals NHS Trust; this was useful in identifying visits by Saville, tracing staff or patient witnesses and corroborating statements.

There were a number of Trusts where no transfers had been made and no records at all had survived.

Where the patient has died the DPA no longer applies, the FOIA becomes the relevant legislation as the FOIA applies regardless as to whether the individual is or is not alive.

Section 41 of the FOIA and the duty of confidence remains relevant and the records cannot be accessed by anyone who does not have a lawful basis to view the records. Section 41 will therefore apply if the applicant does not have a claim under the Access to Health Records Act 1990 and the duty of confidence will need to be considered. An exemption will apply if the disclosure of the information would constitute a breach of confidence actionable by that or any other person. See Pauline Bluck v Information Commissioner and Epsom & St Helier University Hospitals NHS Trust (EA/2006/0090, 17 5 Information about the deceased 20130522 Version: 1.1 September 2007[84])

When a person is deceased the Access to Health Records Act 1990 may be used to access the health record for a limited purpose by specified individuals. Therefore FOIA decisions indicate that, in general, clinical information will remain confidential for several decades after death. The duty of confidence must always be considered to apply unless there can

[84] https://ico.org.uk/media/for-organisations/documents/1202/information-about-the-deceased-foi-eir.pdf

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be no persons who would suffer a detriment if the information were released. This is often quoted as 100 years but will be different for every case[85].

[85] The National Archives -
Access to NHS Records transferred to places of deposit under the Public Records Act 1958:
http://www.nationalarchives.gov.uk/documents/information-management/access-to-nhs-records-transferred-to-places-of-deposit.pdf

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Records Held by Health and Social Care Organisations

See Appendix Three or click on item headings below for full details.

1. **Care Records with standard retention periods**
   - Adult health records
   - Adult social care records
   - Children's records including midwifery, health visiting and school nursing
   - Electronic Patient Records Systems
   - General Dental Services records
   - GP patient records
   - Mental Health records
   - Obstetric records, maternity records and antenatal and post natal records

2. **Care Records with non-standard retention periods**
   - Cancer/oncology - the oncology records of any patient
   - Contraception, sexual health, family planning and Genito-Urinary Medicine (GUM)
   - Human Fertilisation & Embryology Authority (HFEA) records of treatment provided in licenced treatment centres
   - Medical record of a patient with Creutzfeldt-Jakob disease (CJD)
   - Record of long term illness or an illness that may reoccur

3. **Pharmacy Records**
   - Information relating to controlled drugs
   - Pharmacy prescription records - see also Information relating to controlled drugs

4. **Pathology Records**
   - Pathology Reports/Information about specimens and samples

5. **Event & Transaction Records**
   - Blood bank register
   - Clinical Audit
   - Chaplaincy records
   - Clinical Diaries
   - Clinical Protocols
   - Data sets released by HSCIC under a data sharing agreement
   - Destruction Certificates or Electronic Metadata destruction stub or record of clinical information held on destroyed physical media
   - Equipment maintenance logs
   - General Ophthalmic Services patient records related to NHS financial transactions
   - GP temporary resident forms
   - Inspection of equipment records
   - Notifiable disease book
   - Operating theatre records
   - Pathology Reports/Information about Specimens and samples
   - Patient Property Books
   - Referrals not accepted
   - Requests for funding for care not accepted

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- Screening, including cervical screening and information where no cancer/illness is detected
- Smoking cessation
- Transplantation Records
- Ward handover sheet

6. **Telephony Systems & Services Records - 999 phone numbers, 111 phone numbers, ambulance, out of hours and single point of contact call centres.**
   - Recorded conversation which may later be needed for clinical negligence purpose
   - Recorded conversation which forms part of the health record
   - The telephony systems record

7. **Births, Deaths & Adoption Records**
   - Birth Notification to Child Health
   - Birth Registers
   - Body Release Forms
   - Death - cause of death certificate counterfoil
   - Death register information sent to General Registry Office on monthly basis
   - Local Authority Adoption Record (normally held by the local authority children's services)
   - Mortuary records of deceased
   - Mortuary Register
   - NHS medicals for adoption records
   - Post Mortem records

8. **Clinical Trials & Research Records**
   - Advanced Medical Therapy Research Master File
   - Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014
   - European Commission Authorisation (certificate or letter) to enable marketing and sale within the EU member states' area
   - Research data sets
   - Research Ethics Committee's documentation for research proposal
   - Research Ethics Committee's minutes and papers

9. **Corporate Governance Records**
   - Board Meetings
   - Board Meetings (Closed Boards)
   - Chief Executive records
   - Committees Listed in the Scheme of Delegation or that report into the Board and major projects
   - Committees/Groups/sub-committees not listed in the Scheme of Delegation
   - Destruction Certificates or Electronic Metadata destruction stub or record of information held on destroyed physical media
   - Incidents (serious)
   - Incidents (not serious)
   - Non-Clinical Quality Assurance Records
   - Patient Advice and Liaison Service (PALS) records

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- Policies, strategies and operating procedures including business plans

10. Communications

- Intranet site
- Patient information leaflets
- Press releases and important internal communications
- Public consultations
- Website

11. Staff Records & Occupational Health

- Duty Roster (Staff providing Care)
- Exposure monitoring information
- Occupational Health Reports
- Occupational Health Report of Staff member under health surveillance
- Occupational Health Report of Staff member under health surveillance where they have been subject to radiation doses
- Staff Record
- Staff Record Summary
- Timesheets (original record)
- Staff Training records

12. Procurement

- Contracts sealed or unsealed
- Contracts - financial approval files
- Contracts - financial approved suppliers' documentation
- Tenders (successful)
- Tenders (unsuccessful)

13. Estates

- Building plans and records of major building work
- CCTV
- Equipment monitoring and testing and maintenance work where asbestos is a factor
- Equipment monitoring and testing and maintenance work
- Inspection reports
- Leases
- Minor building works
- Photographic collections of service locations and events and activities
- Radioactive Waste
- Sterilix Endoscopic Disinfector Daily Water Cycle Test, Purge Test, Ninhydrin Test
- Surveys

14. Finance Records

- Accounts
- Benefactions
- Debtor records cleared
- Debtor records not cleared
- Donations
- Expenses
- Final annual accounts report
- Financial records of transactions
- Petty cash

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- Private Finance initiative (PFI) files
- Salaries paid to staff
- Superannuation records

15. Legal, Complaints & Information Rights

- Complaints case file
- Fraud case files
- Freedom of Information (FOI) requests and responses and any associated correspondence
- FOI requests where there has been a subsequent appeal
- Industrial relations including tribunal case records
- Litigation records
- Patents / trademarks / copyright / intellectual property
- Software licences
- Subject Access Requests (SAR) and disclosure correspondence
- Subject access requests where there has been a subsequent appeal

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Useful websites and links

Archives and Records Association: http://www.archives.org.uk/

British Association for Sexual Health and HIV - Guidelines:
http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx?hkey=072c83ed-0e9b-44b2-a989-7c84e4fbd9de

Department of Health Information Governance Toolkit (hosted by the HSCIC):
https://nww.igt.hscic.gov.uk/

Department of Health - Reference guide to consent for examination or treatment 2009 Second edition:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

Directions given under the Human Fertilisation and Embryology Act 1990 as amended:
http://www.hfea.gov.uk/docs/General_directions_0012.pdf

Information Commissioner's Office: https://ico.org.uk/

Information and Records Management Society: http://www.irms.org.uk/

Information Governance Alliance: www.hscic.gov.uk/iga

Local Government Association ESD standards: http://standards.esd.org.uk/?

Ministry of Justice: Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000 (2009):
https://ico.org.uk/media/for-organisations/research-and-reports/1432475/foi-section-46-code-of-practice-1.pdf

The National Archives: http://www.nationalarchives.gov.uk/

The National Archives - Records management in SharePoint 2010-Implications and issues:
http://www.nationalarchives.gov.uk/documents/information-management/review-of-records-management-in-sharepoint-2010.pdf

NHS Scotland - Decommissioning of NHS Premises:
http://www.gov.scot/resource/doc/310165/0097865.pdf

NHS Security Management Service - Procedures for placing a risk of violence marker on electronic and paper records:
http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Procedures.pdf

Professional Record Standards Body for health and social care:
http://theprsb.org/standards-matters/

Royal College of Nursing - Abbreviations and other short forms in patient/client records:
http://www.rcn.org.uk/__data/assets/pdf_file/0011/328925/003595.pdf

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The State Records Authority of New South Wales - Managing authentic and reliable records in SharePoint 2010:
http://www.records.nsw.gov.au/recordkeeping/advice/designing-implementing-and-managing-systems/sharepoint-2010-recordkeeping-considerations/managing-authentic-and-reliable-records#5.1%20Access%20and%20security

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Appendix One

The Information Governance Alliance and the Department of Health are very grateful to the following that provided their time and expertise on the project group, authoring team and reviewing team developing this update:

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Appendix Two

The main standards setting bodies for health and care in England are:

- Academy of Medical Royal Colleges (AoMRC) (hosted by the Royal College of Physicians)
  https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards
- British Medical Association
  http://bma.org.uk/practical-support-at-work/ethics/confidentiality-and-health-records
- General Medical Council
  http://www.gmc-uk.org/guidance/index.asp
- Health and Care Professions Council
  http://www.hcpc-uk.org/
- Nursing and Midwifery Council
  https://www.nmc.org.uk/standards/code/

  Royal College of General Practitioners (with the DH and the BMA)
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215680/dh_125350.pdf
- Royal College of Nursing
  http://www.rcn.org.uk/development/health_care_support_workers/professional_issues/record_keeping
- Royal College of Obstetricians & Gynaecologists
  https://www.rcog.org.uk/en/guidelines-research-services/guidelines/
- Royal College of Pathologists
  http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/G031_RetentionAndStorage_Apr15.pdf
- Royal Pharmaceutical Society
  http://www.rpharms.com/home/about-pharmacy.asp
- Royal College of Physicians
  https://www.rcplondon.ac.uk/
- Standardisation Committee for Care Information
  http://www.hscic.gov.uk/isce

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Section	Occupational Health Report of Staff member under health surveillance	Retention start	Retention period	Action at end of retention period	Notes
1. Care Records with standard retention periods	Adult health records not covered by any other section in this schedule	Discharge or patient last seen	8 Years	Review and if no longer needed destroy	Basic health and social care retention period - check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
1. Care Records with standard retention periods	Adult social care records	End of care or client last seen	8 Years	Review and if no longer needed destroy	
1. Care Records with standard retention periods	Children's records including midwifery, health visiting and school nursing	Discharge or patient last seen	25th or 26th birthday (see Notes)	Review and if no longer needed destroy	Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
1. Care Records with standard retention periods	Electronic Patient Records System (EPR) NB: The IGA is undertaking further work to refine the rules for record retention and to specify requirements for EPR systems	See Notes	See Notes	Destroy	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the Code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.

1. Care Records with standard retention periods	General Dental Services records	Discharge or patient last seen	10 Years	Review and if no longer needed destroy	
1. Care Records with standard retention periods	GP Patient records	Death of a patient	10 years after death - see Notes for exceptions	Review and if no longer needed destroy	If a new provider requests the records, these are transferred to the new provider to continue care. If no request to transfer: · Where the patient does not come back to the practice and the records are not transferred to a new provider the record must be retained for 100 years unless it is known that they have emigrated · Where a patient is known to have emigrated records may be reviewed and destroyed after 10 years · If the patient comes back within the 100 years, the retention reverts to 10 years after death.
1. Care Records with standard retention periods	Mental Health records	Discharge or patient last seen	20 years or 8 years after the patient has died	Review and if no longer needed destroy	Covers records made where the person has been cared for under the Mental Health Act 1983 as amended by the Mental Health Act 2007. This includes psychology records. Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer than 20 years where the case may be ongoing. Very mild forms of adult mental health treated in a community setting where a full recovery is made may consider treating as an adult records and keep for 8 years after discharge. All must be reviewed prior to destruction taking into account any serious incident retentions.
1. Care Records with standard retention periods	Obstetric records, maternity records and antenatal and post natal records	Discharge or patient last seen	25 Years	Review and if no longer needed destroy	For the purposes of record keeping these records are to be considered as much a record of the child as that of the mother.

2. Care Records with Non-Standard Retention Periods	Cancer/Oncology - the oncology records of any patient	Diagnosis of Cancer	30 Years or 8 years after the patient has died		For the purposes of clinical care the diagnosis records of any cancer must be retained in case of future reoccurrence. Where the oncology records are in a main patient file the entire file must be retained. Retention is applicable to primary acute patient record of the cancer diagnosis and treatment only. If this is part of a wider patient record then the entire record may be retained. Any oncology records must be reviewed prior to destruction taking into account any potential long term research value which may require consent or anonymisation of the record.
2. Care Records with Non-Standard Retention Periods	Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM)	Discharge or patient last seen	8 or 10 years (see Notes)	Review and if no longer needed destroy	Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction taking into account any serious incident retentions. If this is a record of a child, treat as a child record as above.
2. Care Records with Non-Standard Retention Periods	HFEA records of treatment provided in licenced treatment centres		3, 10, 30, or 50 years	Review and if no longer needed destroy	Retention periods are set out in the HFEA guidance at: http://www.hfea.gov.uk/docs/General_directions_0012.pdf
2. Care Records with Non-Standard Retention Periods	Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)	Diagnosis	30 Years or 8 years after the patient has died	*Review and consider transfer to a Place of Deposit	For the purposes of clinical care the diagnosis records of CJD must be retained. Where the CJD records are in a main patient file the entire file must be retained. All must be reviewed prior to destruction taking into account any serious incident retentions.
2. Care Records with Non-Standard Retention Periods	Record of long term illness or an illness that may reoccur	Discharge or patient last seen	30 Years or 8 years after the patient has died	Review and if no longer needed destroy	Necessary for continuity of clinical care. The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life long illness.

3. Pharmacy	For information Only	For information Only	For information Only	For information Only	The IGA are conducting further work to expand this section which will be updated in the near future. As an interim measure you can view a list of Pharmacy records and their associated retention periods and actions by clicking on this link to the NHS East and South East Specialist Pharmacy Services retention schedule.
3. Pharmacy	Information relating to controlled drugs	Creation	See Notes	Review and if no longer needed destroy	NHS England and NHS BSA guidance for controlled drugs can be found at: http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx and https://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf The Medicines, Ethics and Practice (MEP) guide can be found at the link (subscription required): http://www.rpharms.com/support/mep.asp Guidance from NHS England is that locally held controlled drugs information should be retained for 7 years. NHS BSA will hold primary data for 20 years and then review. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/
3. Pharmacy	Pharmacy prescription records. See also Information relating to controlled drugs.	Discharge or patient last seen	2 Years	Review and if no longer needed destroy	There will also be an entry in the patient record and a record held by the NHS Business Services Authority. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/

4. Pathology	Pathology Reports/Information about specimens and samples	Specimen or sample is destroyed	See Notes	*Review and consider transfer to a Place of Deposit	This Code is concerned with the information about a specimen or sample. The length of storage of the clinical material will drive the length of time the information about it is to be kept. For more details please see: https://www.rcpath.org/resourceLibrary/the-retention-and-storage-of-pathological-records-and-specimens--5th-edition-.html Retention of samples for clinical purposes can be for as long as there is a clinical need to hold the specimen or sample. Reports should be stored on the patient file. It is common for pathologists to hold duplicate reports. For clinical purposes this is 8 years after the patient is discharged for an adult or until a child's 25th birthday whichever is the longer. After 20 years for adult records there must be an appraisal as to the historical importance of the information and a decision made as to whether they should be destroyed of kept for archival value.
5. Event & Transaction Records	Blood bank register	Creation	30 Years minimum	*Review and consider transfer to a Place of Deposit	
5. Event & Transaction Records	Clinical Audit	Creation	5 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	Chaplaincy records	Creation	2 Years	*Review and consider transfer to a Place of Deposit	See also Corporate Governance Records
5. Event & Transaction Records	Clinical Diaries	End of the year to which they relate	2 Years	Review and if no longer needed destroy	Diaries of clinical activity & visits must be written up and transferred to the main patient file. If the information is not transferred the diary must be kept for 8 years.
5. Event & Transaction Records	Clinical Protocols	Creation	25 Years	*Review and consider transfer to a Place of Deposit	Clinical protocols may have archival value. They may also be routinely captured in clinical governance meetings which may form part of the permanent record (see Corporate Records).

5. Event & Transaction Records	Datasets released by HSCIC under a data sharing agreement	Date specified in the data sharing agreement	Delete with immediate effect	Delete according to HSCIC instruction	http://www.hscic.gov.uk/media/15729/DARS-Data-Sharing-Agreement/pdf/Data_Sharing_Agreement_2015v2%28restricted_editing%29.pdf
5. Event & Transaction Records	Destruction Certificates or Electronic Metadata destruction stub or record of clinical information held on destroyed physical media	Destruction of record or information	20 Years	*Review and consider transfer to a Place of Deposit	Destruction certificates created by public bodies are not covered by an instrument of retention and if a Place of Deposit or the National Archives do not class them as a record of archival importance they are to be destroyed after 20 years.
5. Event & Transaction Records	Equipment maintenance logs	Decommission-ing of the equipment	11 Years	*Review and consider transfer to a Place of Deposit	
5. Event & Transaction Records	General Ophthalmic Services patient records related to NHS financial transactions	Discharge or patient last seen	6 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	GP temporary resident forms	After Treatment	2 Years	Review and if no longer needed destroy	Assumes a copy sent to the responsible GP for inclusion in the primary care record
5. Event & Transaction Records	Inspection of equipment records	Decommission-ing of the equipment	11 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	Notifiable disease book	Creation	6 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	Operating theatre records	End of year to which they relate	10 Years	*Review and consider transfer to a Place of Deposit	If transferred to a Place of Deposit the duty of confidence continues to apply and can only be used for research if the patient has consented or the record is

					anonymised.
5. Event & Transaction Records	Patient Property Books	End of year to which they relate	2 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	Referrals not accepted	Date of Rejection	2 years as an ephemeral record	Review and if no longer needed destroy	The rejected referral to the service should also be kept on the originating service file.
5. Event & Transaction Records	Requests for funding for care not accepted	Date of Rejection	2 years as an ephemeral record	Review and if no longer needed destroy	
5. Event & Transaction Records	Screening, including cervical screening, information where no cancer/illness detected is detected	Creation	10 Years	Review and if no longer needed destroy	Where cancer is detected see 2 Cancer / Oncology. For child screening treat as a child health record and retain until 25th birthday or 10 years after the child has been screened whichever is the longer.
5. Event & Transaction Records	Smoking cessation	Closure of 12 week quit period	2 Years	Review and if no longer needed destroy	
5. Event & Transaction Records	Transplantation Records	Creation	30 Years	*Review and consider transfer to a Place of Deposit	See guidance at: https://www.hta.gov.uk/codes-practice
5. Event & Transaction Records	Ward handover sheet	Date of Handover	2 Years	Review and if no longer needed destroy	This retention relates to the ward. The individual sheets held by staff must be destroyed confidentially at the end of the shift.
6. Telephony Systems & Services	For information Only	For information Only	For information Only	For information Only	(999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).

6. Telephony Systems & Services	Recorded conversation which may later be needed for clinical negligence purpose	Creation	3 Years	Review and if no longer needed destroy	The period of time cited by the NHS Litigation Authority is 3 years
6. Telephony Systems & Services	Recorded conversation which forms part of the health record	Creation	Store as a health record	Review and if no longer needed destroy	It is advisable to transfer any relevant information into the main record through transcription or summarisation. Call handlers may perform this task as part of the call. Where it is not possible to transfer clinical information from the recording to the record the recording must be considered as part of the record and be retained accordingly.
6. Telephony Systems & Services	The telephony systems record (not recorded conversations)	Creation	1 Year	Review and if no longer needed destroy	This is the absolute minimum specified to meet the NHS contractual requirement.
7. Births, Deaths & Adoption Records	Birth Notification to Child Health	Receipt by Child health department	25 Years	Review and if no longer needed destroy	Treat as a part of the child's health record if not already stored within health record such as the health visiting record.
7. Births, Deaths & Adoption Records	Birth Registers	Creation	2 Years	*Review and consider transfer to a Place of Deposit	Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and offered to a Place of Deposit at the end of this retention period. Information is also held in the NHS Birth Notification Service electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.
7. Births, Deaths & Adoption Records	Body Release Forms	Creation	2 Years	*Review and consider transfer to a Place of Deposit	

7. Births, Deaths & Adoption Records	Death - cause of death certificate counterfoil	Creation	2 Years	*Review and consider transfer to a Place of Deposit	
7. Births, Deaths & Adoption Records	Death register information sent to General Registry Office on monthly basis	Creation	2 Years	*Review and consider transfer to a Place of Deposit	A full dataset is available from the Office for National Statistics.
7. Births, Deaths & Adoption Records	Local Authority Adoption Record (normally held by the Local Authority children's services)	Creation	100 years from the date of the adoption order	*Review and consider transfer to a Place of Deposit	The primary record of the adoption process is held by the local authority children's service responsible for the adoption service.
7. Births, Deaths & Adoption Records	Mortuary Records of deceased	End of year to which they relate	10 Years	*Review and consider transfer to a Place of Deposit	
7. Births, Deaths & Adoption Records	Mortuary Register	Creation	10 Years	*Review and consider transfer to a Place of Deposit	
7. Births, Deaths & Adoption Records	NHS Medicals for Adoption Records	Creation	8 years or 25th birthday	*Review and consider transfer to a Place of Deposit	The health reports will feed into the primary record held by the local authority children's services. This means that the adoption records held in the NHS relate to reports that are already kept in another file which is kept for 100 years by the appropriate agency and local authority.
7. Births, Deaths & Adoption Records	Post Mortem Records	Creation	10 years	Review and if no longer needed destroy	The primary post mortem file will be maintained by the coroner. The coroner will retain the post mortem file including the report. Local records of post mortem will not need to be kept for the same extended time.
8. Clinical Trials & Research	For information Only	For information Only	For information Only	For information Only	For clinical trials record retention please see the MHRC guidance at https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials

8. Clinical Trials & Research	Advanced Medical Therapy Research Master File	Closure of research	30 years	*Review and consider transfer to a Place of Deposit	See guidance at: https://www.gov.uk/guidance/advanced-therapy-medicinal-products-regulation-and-licensing
8. Clinical Trials & Research	Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014	Closure of trial	25 years	*Review and consider transfer to a Place of Deposit	For details please see: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.0001.01.ENG
8. Clinical Trials & Research	European Commission Authorisation (certificate or letter) to enable marketing and sale within the EU member states area	Closure of trial	15 Years	*Review and consider transfer to a Place of Deposit	For details please see: http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf
8. Clinical Trials & Research	Research data sets	End of Research	Not more than 20 years	*Review and consider transfer to a Place of Deposit	For details please see: http://tools.jiscinfonet.ac.uk/downloads/bcs-rrs/managing-research-records.pdf

8. Clinical Trials & Research	Research Ethics Committee's documentation for research proposal	End of Search	5 years	*Review and consider transfer to a Place of Deposit	For details please see: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/ Data must be held for sufficient time to allow any questions about the research to be answered. Depending on the type of research the data may not need to be kept once the purpose has expired. For example data used for passing an academic exam may be destroyed once the exam has been passed and there is no further academic need to hold the data. For more significant research a Place of Deposit may be interested in holding the research. It is best practice to consider this at the outset of research as orphaned personal data can inadvertently cause a data breach.
8. Clinical Trials & Research	Research Ethics Committee's minutes and papers	Year to which they relate	Before 20 years but as soon as practically possible	*Review and consider transfer to a Place of Deposit	Committee papers must be transferred to a Place of Deposit as a public record: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/
9. Corporate Governance	Board Meetings	Creation	Before 20 years but as soon as practically possible	Transfer to a place of deposit	
9. Corporate Governance	Board Meetings (Closed Boards)	Creation	May retain for 20 years	Transfer to a place of deposit	Although they may contain confidential or sensitive material they are still a public record and must be transferred at 20 years with any FOI exemptions noted or duty of confidence indicated.
9. Corporate Governance	Chief Executive records	Creation	May retain for 20 years	Transfer to a place of deposit	This may include emails and correspondence where they are not already included in the board papers and they are considered to be of archival interest.

9. Corporate Governance	Committees Listed in the Scheme of Delegation or that report into the Board and major projects	Creation	Before 20 years but as soon as practically possible	Transfer to a place of deposit	
9. Corporate Governance	Committees/ Groups / Sub-committees not listed in the scheme of delegation	Creation	6 years	Review and if no longer needed destroy	Includes minor meetings/projects and departmental business meetings
9. Corporate Governance	Destruction Certificates or Electronic Metadata destruction stub or record of information held on destroyed physical media	Destruction of record or information	20 Years	Consider Transfer to a Place of Deposit and if no longer needed to destroy	The Public Records Act 1958 limits the holding of records to 20 years unless there is an instrument issued by the Minister with responsibility for administering the Act. If records are not excluded by such an instrument they must either be transferred to a Place of Deposit as a public record or destroyed 20 years after the record has been closed.
9. Corporate Governance	Incidents (serious)	Date of Incident	20 Years	*Review and consider transfer to a Place of Deposit	
9. Corporate Governance	Incidents (not serious)	Date of Incident	10 Years	Review and if no longer needed destroy	
9. Corporate Governance	Non-Clinical Quality Assurance Records	End of year to which the assurance relates	12 Years	Review and if no longer needed destroy	
9. Corporate Governance	Patient Advice and Liaison Service (PALS) records	Close of financial year	10 Years	Review and if no longer needed destroy	

9. Corporate Governance	Policies, strategies and operating procedures including business plans	Creation	Life of organisa-tion plus 6 years	*Review and consider transfer to a Place of Deposit	
10. Communications	Intranet site	Creation	6 Years	*Review and consider transfer to a Place of Deposit	
10. Communications	Patient information leaflets	End of Use	6 Years	*Review and consider transfer to a Place of Deposit	
10. Communications	Press releases and important internal communications	Release Date	6 Years	*Review and consider transfer to a Place of Deposit	Press releases may form a significant part of the public record of an organisation which may need to be retained
10. Communications	Public consultations	End of Consultation	5 Years	*Review and consider transfer to a Place of Deposit	
10. Communications	Website	Creation	6 Years	*Review and consider transfer to a Place of Deposit	
11. Staff Records & Occupational Health	For information Only	For information Only	For information Only	For information Only	Although pension information is routinely retained until 100th birthday by the NHS Pensions Agency employers must retain a portion of the staff record until the 75th birthday.
11. Staff Records & Occupational Health	Duty Roster	Close of financial year	6 Years	Review and if no longer needed destroy	
11. Staff Records & Occupational Health	Exposure Monitoring information	Monitoring Ceases	40 years/5 years from the date of the last entry made in it	Review and if no longer needed destroy	A) Where the record is representative of the personal exposures of identifiable employees, for at least 40 years or B) In any other case, for at least 5 years.

11. Staff Records & Occupational Health	Occupational Health Reports	Staff member leaves	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	Review and if no longer needed destroy	
11. Staff Records & Occupational Health	Occupational Health Report of Staff member under health surveillance	Staff member leaves	Keep until 75th birthday	Review and if no longer needed destroy	
11. Staff Records & Occupational Health	Occupational Health Report of Staff member under health surveillance where they have been subject to radiation doses	Staff member leaves	50 years from the date of the last entry or until 75th birthday, whichever is longer	Review and if no longer needed destroy	
11. Staff Records & Occupational Health	Staff Record	Staff member leaves	Keep until 75th birthday (see Notes)	Create Staff Record Summary then review or destroy the main file	This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms. May be destroyed 6 years after the staff member leaves or the 75th birthday, whichever is sooner, if a summary has been made.
11. Staff Records & Occupational Health	Staff Record Summary	6 Years afer staff member leaves	75th Birthday	Place of Deposit should be offered for continued retention or Destroy	Please see the good practice box Staff Record Summary used by an organisation.
11. Staff Records & Occupational Health	Timesheets (original record)	Creation	2 years	Review and if no longer needed destroy	

	Staff Training records	Creation	See Notes	*Review and consider transfer to a Place of Deposit	Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The IGA recommends: · Clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer · Statutory and mandatory training records - to be kept for ten years after training completed · Other training records - keep for six years after training completed.
12. Procurement	Contracts sealed or unsealed	End of Contract	6 Years	Review and if no longer needed destroy	
12. Procurement	Contracts - financial approval files	End of Contract	15 Years	Review and if no longer needed destroy	
12. Procurement	Contracts - financial approved suppliers documentation	When supplier finishes work	11 Years	Review and if no longer needed destroy	
12. Procurement	Tenders (successful)	End of Contract	6 Years	Review and if no longer needed destroy	
12. Procurement	Tenders (unsuccessful)	Award of Tender	6 Years	Review and if no longer needed destroy	
13. Estates	Building plans and records of major building work	Completion of work	Lifetime of the building or disposal of asset plus six years	*Review and consider transfer to a Place of Deposit	Building plans and records of works are potentially of historical interest and where possible be kept and transferred to a place of deposit

13. Estates	CCTV		See ICO Code of Practice	Review and if no longer needed destroy	ICO Code of Practice: https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf The length of retention must be determined by the purpose for which the CCTV has been deployed. The recorded images will only be retained long enough for any incident to come to light (e.g. for a theft to be noticed) and the incident to be investigated.
13. Estates	Equipment monitoring and testing and maintenance work where asbestos is a factor	Completion of monitoring or test	40 Years	Review and if no longer needed destroy	
13. Estates	Equipment monitoring and testing and maintenance work	Completion of monitoring or test	10 Years	Review and if no longer needed destroy	
13. Estates	Inspection reports	End of lifetime of installation	Lifetime of installation	"Review	
13. Estates	Leases	Termination of lease	12 Years	Review and if no longer needed destroy	
13. Estates	Minor building works	Completion of work	6 Years	Review and if no longer needed destroy	
13. Estates	Photographic collections of service locations and events and activities	Close of collection	Retain for not more than 20 years	Consider Transfer to a Place of Deposit	The main reason for maintaining photographic collections is for historical legacy of the running and operation of an organisation. However, photographs may have subsidiary uses for legal enquiries.

13. Estates	Radioactive Waste	Creation	30 years	Review and if no longer needed destroy	
13. Estates	Sterilix Endoscopic Disinfector Daily Water Cycle Test, Purge Test, Ninhydrin Test	Date of test	11 Years	Review and if no longer needed destroy	
13. Estates	Surveys	End of lifetime of installation or building	Lifetime of installation or building	*Review and consider transfer to a Place of Deposit	
14. Finance	Accounts	Close of financial year	3 Years	Review and if no longer needed destroy	Includes all associated documentation and records for the purpose of audit as agreed by auditors
14. Finance	Benefactions	End of financial year	8 Years	*Review and consider transfer to a Place of Deposit	These may already be in the financial accounts and may be captured in other records/reports or committee papers. For benefactions, endowment, trust fund/legacies, offer to a Place of Deposit.
14. Finance	Debtor records cleared	Close of financial year	2 Years	Review and if no longer needed destroy	
14. Finance	Debtor records not cleared	Close of financial year	6 Years	Review and if no longer needed destroy	
14. Finance	Donations	Close of financial year	6 Years	Review and if no longer needed destroy	
14. Finance	Expenses	Close of financial year	6 Years	Review and if no longer needed destroy	

14. Finance	Final annual accounts report	Creation	Before 20 years	Transfer to place of deposit if not transferred with the board papers	Should be transferred to a place of deposit as soon as practically possible
14. Finance	Financial records of transactions	End of financial year	6 Years	Review and if no longer needed destroy	
14. Finance	Petty cash	End of financial year	2 Years	Review and if no longer needed destroy	
14. Finance	Private Finance initiative (PFI) files	End of PFI	Lifetime of PFI	Review and if no longer needed destroy	
14. Finance	Salaries paid to staff	Close of financial year	10 Years	Review and if no longer needed destroy	
14. Finance	Superannuation records	Close of financial year	10 Years	Review and if no longer needed destroy	
15. Legal, Complaints & Information Rights	Complaints case file	Closure of incident (see Notes)	10 Years	Review and if no longer needed destroy	http://www.nationalarchives.gov.uk/documents/information-management/sched_complaints.pdf The incident is not closed until all subsequent processes have ceased including litigation. The file must not be kept on the patient file. A separate file must always be maintained.
15. Legal, Complaints & Information Rights	Fraud case files	Case closure	6 Years	Review and if no longer needed destroy	
15. Legal, Complaints & Information Rights	Freedom of Information (FOI) requests and responses and any associated correspondence	Closure of FOI request	3 Years	Review and if no longer needed destroy	Where redactions have been made it is important to keep a copy of the redacted disclosed documents or if not practical to keep a summary of the redactions.

15. Legal, Complaints & Information Rights	FOI requests where there has been a subsequent appeal	Closure of appeal	6 Years	Review and if no longer needed destroy	
15. Legal, Complaints & Information Rights	Industrial relations including tribunal case records	Close of financial year	10 years	*Review and consider transfer to a Place of Deposit	Some organisations may record these as part of the staff record but in most cases they will form a distinct separate record either held by the staff member/manager or by the payroll team for processing.
15. Legal, Complaints & Information Rights	Litigation records	Closure of case	10 years	*Review and consider transfer to a Place of Deposit	
15. Legal, Complaints & Information Rights	Patents / trademarks / copyright / intellectual property-	End of lifetime of patent or termination of licence/ action	Lifetime of patent or 6 years from end of licence/ action	*Review and consider transfer to a Place of Deposit	
15. Legal, Complaints & Information Rights	Software licences	End of lifetime of software	Lifetime of software	Review and if no longer needed destroy	
15. Legal, Complaints & Information Rights	Subject Access Request (SAR) and disclosure correspondence	Closure of SAR	3 Years	Review and if no longer needed destroy	
15. Legal, Complaints & Information Rights	Subject Access Request where there has been a subsequent appeal	Closure of appeal	6 Years	Review and if no longer needed destroy	