Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title:
Retention of All Clinical and Corporate Records Guidance (Including Transfer of Care to a New External Provider)

Version: 3

Reference Number: CO98

Due to the Independent Inquiry into Child Sexual Abuse all records should be retained until further notice. This means all clinical and corporate records in whichever format held i.e. paper or electronic.

For further information please contact the Records Manager on 0161 716 3263 or carole.mccarthy1@nhs.net

Supersedes: V2
Description of Amendment(s):

- **Retention schedule revision by the Information Governance Alliance on behalf of the Department of Health in the new Records Management Code of Practice for Health and Social Care 2016. The retention schedule has been rationalised and condensed for ease of use.**
- **There have been some revisions in retention due to changes in legislation e.g. Staff leavers records are now retained until their 75th birthday rather than 70th. Changes are highlighted in the end column for ease of use.**
- **The retention schedule also now covers the transfer of care to new external providers.**

Important Notice
From May 2018 the UK will be adopting the European General Data Protection Regulations. These regulations will be replacing the Data Protection Act 1998. In the UK we are still awaiting some health sector specific guidance and instruction regarding GDPR, and as such have deemed that, unless there is a legal requirement or a fundamental change that is required in a policy, all policies, regardless of review date, shall remain current, valid and must be followed for the foreseeable future, to be reviewed prior to the implementation of GDPR from May 2018. Any queries in relation to this statement should be directed to the Trust Information Governance Manager.

Originator

Originated By: Carole McCarthy

Designation: Records Manager

Equality Analysis Assessment (EAA) Process

Equality Relevance Assessment Undertaken by: Information Governance Manager
ERA undertaken on: 10th October 2016
ERA approved by EIA Work group on: 9th December 2016

Where policy deemed relevant to equality- NO
EIA undertaken by Carole McCarthy
EIA undertaken on
EIA approved by EIA work group on

Approval and Ratification

Referred for approval by: Records Manager

Date of Referral: 21st October 2016

Approved by: Information Governance Assurance Group

Approval Date: 21st October 2016

Date Ratified Executive Directors : 19th December 2016

Executive Director Lead: Medical Director

Circulation

Issue Date: 12th January 2016

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? Yes

Review: 2 years

Review Date: 19th December 2018

Responsibility of: Carole McCarthy

Designation: Records Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 12th January 2017

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FOREWORD

At the time of updating this guidance the Independent Inquiry into Child Sexual Abuse (IICSA) has requested that NHS and Social Care bodies do not destroy any records that are, or may fall, into the remit of the Inquiry. This includes children's records and any instances of allegations or investigations or any records of institution where abuse has, or may have occurred. Additional guidance will be published if this should change.

1. INTRODUCTION

This guidance sets out the minimum periods for which the various records created within the Trust should be retained, either due to their on-going administrative value or as a result of statutory requirement. It also provides guidance on dealing with records, which have on-going research or historical value and should be selected for permanent preservation as archives and transferred to a Place of Deposit approved by The National Archives.

This guidance provides information and advice about all records commonly found within NHS organisations and includes both clinical and corporate records. Clinical records are those records used in the treatment/care of patients or service users whereas corporate records relate to the business administrative function such as finance, HR, Estates etc.

This document supports the Records Management Policy and should be read in conjunction with the Records Management Policy (CO20); the Protocol for the Management of Community Health Records (CO99); the Protocol for the Management of Mental Health and Specialist Services Health Records (CO93); the Business and Corporate Records Management Protocol (CO97) and the Missing Records Procedure (CO28).

The retention schedule applies to all the records concerned, irrespective of the format (e.g. paper, electronic, databases, e-mails, X-rays, photographs, CD-ROMs) in which they are created or held.

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2. INTERPRETATION OF THE SCHEDULE

2.1 MINIMUM RETENTION PERIOD

Records are required to be kept for a certain period either because of statutory requirement or because they may be needed for administrative purposes during this time. **The retention periods listed in this schedule must always be considered a minimum.**

Records should always be reviewed at the point that records reach their retention period as the Trust may decide to keep records longer than the recommended

minimum period, it can vary the period accordingly and the decision will be recorded and the reasons behind it within the retention schedule.

2.2 PLACE of DEPOSIT (PoD)
Retention periods given in this schedule are those for operational purposes. Selection for transfer under the Public Records Act 1958 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.

Records must be selected in accordance with the guidance contained within the Records Management Code of Practice for Health & Social Care 2016 and any supplementary guidance issued by the National Archives or local guidance from the relevant PoD. Records may be selected as a class (for example Board minutes) or at lower levels such as individual files or items by the Records Manager/ Caldicott Guardian or Information Governance Manager. Any records being transferred to a PoD will be reported to the Information Governance Assurance Group. Where it is known a record will form part of the public record at creation, it must be preserved within the Trust until such time it can be transferred. The retention periods must be applied at creation and not part of a reactive process such as organisational change.

Any health records selected should normally be retained within the Trust until the patient is known, or assumed to be deceased. This is so that they can continue to be readily available to support further medical care if necessary.

The selection of any health records for transfer to PoD should only be agreed after consultation with the appropriate clinician's, including the Caldicott Guardian and research lead.

The following factors should be taken into account when considering selection of health 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.

Health records are problematic to preserve permanently in an archive or by the organisations that created them. Following appraisal, health 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 Data Protection Act 1958 (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.

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.

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 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[1].

3. APPRAISAL OF RECORDS

The process of deciding what to do with records when their business use has ceased is called appraisal.

There will be one of three outcomes from appraisal:

- Destroy/delete
- To keep for a longer period
- To transfer to a place of deposit.

Staff in the operational area that ordinarily uses the records will usually be able to decide whether to destroy or keep for a longer period. Operational managers are responsible for making sure that all records are periodically and routinely reviewed to determine what can be disposed of or destroyed in the light of local and national guidance.

[1] 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

Once the appropriate minimum period has expired, the need to retain records further for local use should be reviewed periodically. Because of the sensitive and confidential nature of such records and the need to ensure that decisions on retention balance the interests of professional staff, including any research in which they are or may be engaged, and the resources available for storage, it is recommended that the views of the profession's local representatives should be obtained.
Electronic records can be appraised if they are arranged in an organised filing system which can differentiate the year the records were created and the subject of the record. If electronic records have been organised in an effective file plan or an electronic record keeping system, this process will be made much easier. Decisions can then be applied to an entire class of records rather than reviewing each record in turn.
See section 2.2 for records identified by the Records Manager which are suitable to transfer to the PoD.

4. DESTRUCTION OF RECORDS

4.1 Paper: paper records can be destroyed to an international standard. They can be incinerated, pulped or shredded (using a cross cut shredder) under confidential conditions. Do not use the domestic waste or put them on a rubbish tip, because they remain accessible to anyone who finds them. Confidential waste receptacles e.g. red bins/ confidential waste bags/ shredders must be used for the secure disposal of all confidential information. The relevant standard for destruction in all formats is BSIA EN15713:2009 - Secure Destruction of Confidential Material[2].
As referenced in the retention schedule, it is important to keep accurate records of destruction and appraisal decisions. Destruction implies a permanent action. For electronic records 'deletion' may be reversed and may not meet the standard as the information can/may be able to be recovered or reversed.

4.2 Digital media: destruction of digital information is more challenging. Records management is concerned with accounting for information so any destruction of hard assets, like computers and hard drives and backup tapes, must be auditable in respect of the information they hold. An electronic records management system will retain a metadata stub which will show what has been destroyed**.**

5. RECORDS AT CONTRACT CHANGE

Once a contract ends, any service provider still has a liability for the work they have done and as a general rule at any change of contract the records must be retained until the time period for liability has expired.

In the standard NHS contract there is an option to allow the commissioner to direct a transfer of care records to a new provider for continuity of service and this includes

[2] BSIA EN15713:2009 - http://www.bsia.co.uk/Portals/4/Publications/form_204_id_en15713.pdf

third parties and those working under any qualified provider contracts[3]. This will usually be to ensure the continuity of service provision upon termination of the contract. It is also the case that after the contract period has ended; the previous provider will remain liable for their work. In this instance there may be a need to make the records available for continuity of care or for professional conduct cases.

Where legislation creates or disbands public sector organisations, the legislation will normally specify which organisation holds liability for any action conducted by a former organisation. This may also be a consideration to identify the legal entity which must manage the records.

Where the content of records is confidential, for example health records, it may be necessary to inform the individuals concerned about the change.

Where there is little impact upon those receiving care it may be sufficient to use posters and leaflets to inform people about the change, but more significant changes may require individual communications or obtaining explicit consent. Although the conditions of the DPA may be satisfied in many cases there is still a duty of confidence which requires a patient or client (in some cases) to agree to the transfer.

It is vital to highlight the importance of actively managing records which are stored in off-site storage. This will ensure that the Trust maintains a full inventory of what is held off-site, retention periods are applied to each record, a disposal log is kept, and a privacy impact assessment is conducted on the off-site storage provider. Appendix 1 summarises some possible scenarios and, for each option, patient consent and information sharing agreement or a contract may be required to share the information**.**

6. HOW TO DEAL WITH SPECIFIC TYPES OF RECORDS

6.1 Prison Health Records

When the responsibility for offender health in HM Prison Service transferred from the Ministry of Justice to NHS England, a national computer based record was created to facilitate the provision of care and the transfer of care records associated with inmate transfers throughout imprisonment. However, a significant number of paper records remain and some offender health services operate hybrid paper/electronic heath records.

Prison records should be treated as hospital episodes and may be destroyed after the appropriate retention has been applied. The assumption is that a discharge note has been sent to the GP. Where a patient is sent to prison the GP record must not be destroyed but rather held until release or normal retention periods of GP records have been met.

6.2 Youth Offending Service Records

Due to the nature of youth offending it is common for very short retention periods to be imposed on the general youth offending record. However for purposes of clinical liability and for continuity of care, the health care portion of the record must be

[3] www.england.nhs.uk/nhs-standard-contract/

retained as specified in this Code which will generally be until the 25th birthday of the individual concerned.

6.3 Secure Units for Patients Detained Under the Mental Health Act 1983

Some institutions that deal with offenders are categorised as hospitals because the inmate is considered a patient. Such patient records are classed as mental health records and must be retained for longer periods of time. This is normally in excess of 30 years for purposes of the continuity of care - or another lawful basis for the continued retention is required.

6.4 Family Records

Family records are common within health visiting and in some therapy services where a holistic picture of the family is needed to deliver care. This creates a particular problem when the NHS and social care record keeping systems deal with the individual. It may be necessary to specify one person as the focus of the record and hold the entire record against that individual and link the other family members' records together. This will create an issue when the record is shared or disclosed in some way. Special care must be taken not to disclose information about a third party without a lawful basis to do so (for example consent).

6.5 Child School Health Records

It is good practice for each child to have an individual record. A file for the school or a yearly intake is not considered good practice as this means the record is not about the individual child. The focus of a care record must be the individual and not the legal entity. Furthermore when a child changes school or district a record or copy must also be transferred but only when the receiving authority has confirmed that the child is resident there. Failure to carry this out properly will mean a large number of misplaced records will reside with the wrong child health or school nursing service. Where a child's record is stored on a school premises, access must be restricted to the health staff delivering care unless there is another lawful basis to access the record.

6.6 Integrated Records

Integrated or joint care records create additional issues which must be resolved locally. This includes a means of attributing ownership and access to the records between all parties where there is a lawful basis to access the records.
These arrangements may include:

- Nominating one organisation to own the records
- Separating the records so that each party retains their own information
- Each party keeps their own record but has access to the shared part of the other record.

For each option, some form of patient consent is necessary to enable all parties to access information lawfully which may be implied if the patient has sufficient information to inform them about the shared information and does not object. An information sharing agreement is recommended as a mechanism for providing clarity and transparency on the standards that all participants must meet and the Information Governance Department can provide guidance on this.

6.7 Integrated Viewing Technology and Record Keeping

Many record keeping systems pool records to create a view or portal of information which can then be used to inform decisions. This in effect creates a single digital instance of a record which is only correct at the time of viewing. Where these are used, it may be necessary to recreate the instance of viewing to allow an audit trail of decision making. It may be necessary to make a note in the record that the information has been obtained by this means to attribute the source of evidence for any interventions taken.

6.8 Complaints Records

Where a patient or client complains about a service, it is necessary to keep a separate file relating to the complaint and subsequent investigation. Complaint information should never be recorded in the clinical record. A complaint may be unfounded or involve third parties and the inclusion of that information in the clinical record will mean that the information will be preserved for the life of the record and could cause detrimental prejudice to the relationship between the patient and the health care team.

Where multiple teams are involved in the complaint handling, all the associated records must be amalgamated to form a single record. This will prevent the situation where one part of the organisation does not know what the other has done. It is common for the patient or client to ask to see a copy of their complaint file and it will be easier to deal with if all the relevant material is in one file. Where complaints are referred to the Ombudsman Service a single file will be easier to refer to. The Information Commissioner's Office (ICO) has issued guidance on complaints files and who can have access to them, which will drive what must be stored in them[4].

6.9 Specimens and Samples

The retention of human material is not covered in this Code and is not in scope. The metadata or information about the sample or specimen is in scope. Relevant professional bodies such as the Human Tissue Authority or the Royal College of Pathologists have issued guidance on how long to keep human material.

Just because the human material is not kept for long periods, does not mean that the information about the specimen or sample must be destroyed at the same time. The information about any process involving human material must be kept for continuity of care and legal obligations. The correct place to keep information about the patient is the clinical record and although pathology reports may be retained by the individual pathology departments, a copy must always be included on the patient record.

6.10 Continuing Care Decisions Records

In order to process applications and appeals for funding continuing care, it is necessary for the relevant organisation to have access to clinical records. This will be based on consent and organisations need to have arrangements in place to facilitate sharing or put systems in place to allow access to view records or take copies. Any access must be lawful and the decision to grant access recorded.

[4] https://ico.org.uk/media/for-organisations/documents/1179/access_to_information_held_in_complaint_files.pdf

6.11 Records of Funding

Funding records are primarily administrative records but they contain large amounts of care information and as such must be managed as clinical records for their access and management. This includes having rigorous processes for access and the appropriate lawful basis to share them.

6.12 Adopted Persons Health Records

Notwithstanding any other centrally issued guidance by the Department of Health or Department for Education, the records of adopted persons can only be placed under a new last name when an adoption order has been granted. Before an adoption order is granted, an alias may be used, but more commonly the birth names are used.

Depending on the circumstances of the adoption there may be a need to protect from disclosure any information about a third party. Additional checks before any disclosure of adoption documentation are recommended because of the heightened risk of accidental disclosure.

It is important that any new records, if created, contain sufficient information to allow for a continuity of care. At present the GP would initiate any change of NHS number or identity if it was considered appropriate to do so, following the adoption.

6.13 Health Records of Transgender Persons

A patient can request that their gender be changed in a record by a statutory declaration in writing but this does not give them the same rights as those that can be made by the Gender Recognition Act 2004[5]. The formal legal process (as defined in the Gender Recognition Act 2004) is that a Gender Reassignment Certificate is issued by a Gender Reassignment Panel. At this time a new NHS number can be issued and a new record can be created, if it is the wish of the patient. It is important to discuss with the patient what records are moved into the new record and to discuss how to link any records held in any other institutions with the new record.

6.14 Witness Protection Health Records

Where a record is that of someone known to be under a witness protection scheme, the record must be subject to greater security and confidentiality in terms of information sharing, disclosure and records storage. It may become apparent (such as via accidental disclosure) that the records are those of a person under the protection of the Courts for the purposes of identity. The right to anonymity extends to health records. For people under certain types of witness protection, the patient will be given a new name and NHS Number, so the records may appear to be that of a different person.

6.15 Controlled Drugs Regime

NHS England in conjunction with the NHS Business Services Authority has established procedures for handling information relating to controlled drugs. This

[5] Gender Recognition Act 2004: http://www.legislation.gov.uk/ukpga/2004/7/contents

guidance includes conditions for storage, retention and destruction of information. Where information about controlled drugs is held please refer to NHS England guidance[6].

6.16 Asylum Seeker Records

Any service provided to any client must have a record. For reasons of clinical continuity or professional conduct, records for asylum seekers must be treated in exactly the same way as other health records. Where the asylum seeker is given a patient held record, the provider must satisfy themselves that they have a record of what they have done in case of litigation or matters of professional conduct.

6.17 Occupational Health Records

Occupational health records are not part of the main staff record and for reasons of confidentiality they are held separately. However, it is permitted for reports or summaries to be held in the main staff record where these have been requested by the employer and agreed by the staff member. When occupational health records are outsourced, the organisation must ensure that any contractor can retain the records for the necessary period after the termination of service for purposes of adequately recording any work based health issues.

6.18 Records of non-NHS funded patients treated on NHS premises

Where records of individuals who are not NHS or social care funded are held in the record keeping systems of NHS or social care organisations, they must be kept for the same minimum retention periods as other records outlined in this Code. The same levels of security and confidentiality will also apply.

6.19 Patient/Client Held Records

Where it is necessary to leave records with the individual who is the subject of care, it must be indicated on the records that they remain the property of the issuing organisation and include a return address if they are lost. The Trust must be able to produce a record of their work which includes services delivered in the home where the individual holds the record. Upon the termination of treatment where the records are the sole evidence of the course of treatment or care, they must be recovered and given back to the issuing organisation and the service needs to have a tracking process in place that clearly documents when records have been given back.
A copy can be provided if the individual wishes to retain a copy of the records. Where the individual retains the actual record after care, the organisation must be satisfied it has a record of the contents. An example is a child's red book where the parent retains the record but the contents are also recorded in the health visiting file.

6.20 Records dealt with under the NHS Trusts and Primary Care Trusts (Sexually Transmitted Disease) Directions 2000

The directions impose an additional obligation of confidentiality on employees and trustees of NHS Trusts, Clinical Commissioning Groups, local authority public health functions and those providing services under contract regarding information about sexually transmitted diseases.

[6] http://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf

This obligation differs from patient confidentiality generally as it prohibits some types of sharing, but enables sharing where this supports treatment of patients. For this reason it is common for services dealing with sexually transmitted diseases to partition their record keeping systems to comply with the directions and more generally to meet patient expectations that such records should be treated as particularly sensitive.

7. REVIEW

The guidance provides a key component of information governance arrangements for the Trust. This is an evolving document because standards and practice covered by the retention schedules will change over time and will be subject to regular review and updated as necessary.

Appendix 1: Records at Contract Change

Characteristic of new service provider	Fair processing required[7]	What to transfer?	Sensitive records
NHS provider from same premises and involving the same staff. This may be a merger or regional reconfiguration.	Light- notice on appointment letter explaining that there is a new provider. Local publicity campaign such as signage or posters located on premises.	Entire record or summary of entire caseload.	N/A
Non NHS provider from same premises and involving the same staff. This may be a merger or regional reconfiguration.	Light – notice on appointment letter explaining that there is a new provider. Local publicity campaign involving signage and poster and local communications or advertising.	Copy or summary of entire record of current caseload. Former provider retains the original record.	N/A
NHS provider from different premises but with the same staff.	Light – notice on appointment letter explaining that there is a new provider. Local publicity campaign involving signage and poster and local communications or advertising.	Copy or summary of entire record of current caseload. Former provider retains the original record.	N/A
NHS provider from different premises and different staff.	Moderate – a letter informing patients of the transfer with an opportunity to object or talk to someone about the transfer.	Copy or summary of entire record of current caseload. Orphaned records must be retained by the former provider.	Individual communications may not be possible so consent of current caseload may need to be sought before transfer. It may not be possible to transfer the record without explicit patient consent so in some cases no records will be transferred.
Non NHS provider from different premises but with same staff	Moderate – a letter informing patients of the transfer with an opportunity to object or talk to someone about the transfer.	Copy or summary of entire record of current caseload. Orphaned records must be retained by the former provider.	

[7] Service users must be informed about processing to meet DPA fair processing requirements and to avoid breaching confidentiality – see the ICO Data Sharing Code of Practice https://ico.org.uk/for-organisations/guide-to-data-protection/data-sharing/

Appendix 2:

Records Retention

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
- 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
- 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
- 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

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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. This now includes health visitor adult records which used to be 10 years.	New
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		Same
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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Care Records with standard retention periods	Electronic Patient Records System	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.	New
Care Records with standard retention periods	General Dental Services records	Discharge or patient last seen	10 Years	Review and if no longer needed destroy		Change from 11 years to 10 years

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Care Records with standard retention periods	GP Patient records	Death of 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: 1. 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 2. Where a patient is known to have emigrated, records may be reviewed and destroyed after 10 years 3. If the patient comes back within the 100 years, the retention reverts to 10 years after death.	N/A
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 on-going. 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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Same
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	Review and consider transfer to a Place of Deposit	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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Change was 10 years - see notes
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	Same
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 PoD	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.	Change - includes 8 years on death now
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.	New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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) guidance can be found at the link (subscription required) http://www.rpharms.com/support/mep.asp#new 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. http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/	Same
Pharmacy	Pharmacy prescription records *see also 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/	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Change

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Event & Transaction Records	Blood bank register	Creation	30 Years minimum	Review and consider transfer to a PoD		Same
Event & Transaction Records	Clinical Audit	Creation	5 years	Review and consider transfer to a PoD		Same
Event & Transaction Records	Chaplaincy records	Creation	2 years	Review and consider transfer to a PoD	See also Corporate Retention	Same
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.	Same
Event & Transaction Records	Clinical Protocols	Creation	25 years	Review and consider transfer to a PoD	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).	New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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	New
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 PoD	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.	Change - was permanent
Event & Transaction Records	Equipment maintenance logs	Decommissioning of the equipment	11 years	Review and consider transfer to a PoD		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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		New
Event & Transaction Records	GP temporary resident forms	After treatment	2 years	Review and if no longer needed destroy	Assumes a copy sent to responsible GP for inclusion in the primary care record	New
Event & Transaction Records	Inspection of equipment records	Decommissioning of equipment	11 Years	Review and if no longer needed destroy		Same
Event & Transaction Records	Notifiable disease book	Creation	6 years	Review and if no longer needed destroy		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Event & Transaction Records	Operating theatre records	End of year to which they relate	10 Years	Review and consider transfer to a PoD	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.	N/A
Event & Transaction Records	Patient Property Books	End of the year to which they relate	2 years	Review and if no longer needed destroy		Change - was 6 years
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.	Same
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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Event & Transaction Records	Smoking cessation	Closure of 12 week quit period	2 years	Review and if no longer needed destroy		Same
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	N/A
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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	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	New
Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	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.	New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Same
Births, Deaths & Adoption Records	Birth Registers	Creation	2 years	Review and actively 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 Number for Babies (NN4B) electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.	Same
Births, Deaths & Adoption Records	Body Release Forms	Creation	2 years	Review and consider transfer to a Place of Deposit		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Births, Deaths & Adoption Records	Death - cause of death certificate counterfoil	Creation	2 years	Review and consider transfer to a Place of Deposit		Same
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.	Same
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	N/A

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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 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.	N/A
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.	N/A

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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 see: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.0001.01.ENG	Change
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	http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf	Change
Clinical Trials & Research	Research data sets	End of research	Not more than 20 years	Review and consider transfer to a PoD	http://tools.jiscinfonet.ac.uk/downloads/bcs-rrs/managing-research-records.pdf	New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Clinical Trials & Research	Research Ethics Committee's documentation for research proposal	End of research	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 and orphaned personal data can inadvertently cause a data breach.	New
Clinical Trials & Research	Research Ethics Committee's minutes and papers	Year to which they relate	Before 20 years	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/	New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Corporate Governance	Board Meetings	Creation	Before 20 years but as soon as practically possible	Transfer to a Place of Deposit		Change
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.	Change - was 30 years
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.	New
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		New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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	Change
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 Public Records Act 1958. 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.	Change - was permanent
Corporate Governance	Incidents (serious)	Date of Incident	20 Years	Review and consider transfer to a Place of Deposit		Change - was permanent

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Corporate Governance	Incidents (not serious)	Date of Incident	10 Years	Review and if no longer needed destroy	Includes: Accident Register (Reporting of injuries, diseases and dangerous occurrences register – RIDDOR)	Same
Corporate Governance	Non-Clinical Quality Assurance Records	End of year to which the assurance relates	12 years	Review and if no longer needed destroy		Same
Corporate Governance	Patient Advice and Liaison Service (PALS) records	Close of financial year	10 years	Review and if no longer needed destroy		Same
Corporate Governance	Policies, strategies and operating procedures including business plans	Creation	Life of organisation plus 6 years	Review and consider transfer to a Place of Deposit		Change - was retain current version and any previous version for 3 years

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Communications	Intranet site	Creation	6 years	Review and consider transfer to a PoD		New
Communications	Patient information leaflets	End of use	6 years	Review and consider transfer to a PoD		Same
Communications	Press releases and important internal communications	Release Date	6 years	Review and consider transfer to a PoD	Press releases may form a significant part of the public record of an organisation which may need to be retained	Change - was 7 years
Communications	Public consultations	End of consultation	5 years	Review and consider transfer to a PoD		Same
Communications	Website	Creation	6 years	Review and consider transfer to a PoD		New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Staff Records & Occupational Health	Duty Roster	Close of financial year	6 years	Review and if no longer needed destroy		Change - was 4 years
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.	Same
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		Change - was 70 years
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		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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		Change - was 70 years
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.	Change - was 70 years

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Staff Records & Occupational Health	Staff Record Summary	6 years after the staff member leaves	75th Birthday	Place of Deposit should be offered for continued retention or Destroy	Please see the Business and Corporate Records Protocol (CO97) for an example of a Staff Record Summary used by an organisation.	Same
Staff Records & Occupational Health	Timesheets (original record)	Creation	2 years	Review and if no longer needed destroy		Same
Staff Records & Occupational Health	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: 1 Clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer2 Statutory and mandatory training records - to be kept for ten years after training completed3Other training records - keep for six years after training completed.	Change - was 5 years

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Procurement	Contracts sealed or unsealed	End of contract	6 years	Review and if no longer needed destroy		Same
Procurement	Contracts - financial approval files	End of contract	15 years	Review and if no longer needed destroy		Same
Procurement	Contracts - financial approved suppliers documentation	When supplier finishes work	11 years	Review and if no longer needed destroy		Same
Procurement	Tenders (successful)	End of contract	6 years	Review and if no longer needed destroy		Same
Procurement	Tenders (unsuccessful)	Award of tender	6 years	Review and if no longer needed destroy		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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	Change - was 30 years
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.	Change - was 31 days
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		new

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Estates	Equipment monitoring and testing and maintenance work	Completion of monitoring or test	10 years	Review and if no longer needed destroy		new
Estates	Inspection reports	End of lifetime of installation	Lifetime of installation	Review		Same
Estates	Leases	Termination of lease	12 years	Review and if no longer needed destroy		Same
Estates	Minor building works	Completion of work	retain for 6 years	Review and if no longer needed destroy		New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Change - was 30 years
Estates	Radioactive Waste	Creation	30 years	Review and if no longer needed destroy		N/A
Estates	Sterilix Endoscopic Disinfector Daily Water Cycle Test, Purge Test, Nynhydrin Test	Date of test	11 years	Review and if no longer needed destroy		N/A
Estates	Surveys	End of lifetime of installation or building	Lifetime of installation or building	Review and consider transfer to PoD		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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	Same
Finance	Benefactions	End of financial year	8 years	Review and consider transfer to Place of Deposit	These may already be in the financial accounts and may be captured in other records/reports or committee papers. Where benefactions endowment trust fund/legacies - permanent retention.	Change - was 5 years
Finance	Debtor records cleared	Close of financial year	2 years	Review and if no longer needed destroy		Change - was 6 years
Finance	Debtor records not cleared	Close of financial year	6 years	Review and if no longer needed destroy		Same
Finance	Donations	Close of financial year	6 years	Review and if no longer needed destroy		New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Finance	Expenses	Close of financial year	6 years	Review and if no longer needed destroy		Same
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	Change - was 30 years
Finance	Financial records of transactions	End of financial year	6 Years	Review and if no longer needed destroy		Same
Finance	Petty cash	End of financial year	2 Years	Review and if no longer needed destroy		New

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
Finance	Private Finance initiative (PFI) files	End of PFI	Lifetime of PFI	Review and consider transfer to PoD		Change - was 30 years
Finance	Salaries paid to staff	Close of financial year	10 Years	Review and if no longer needed destroy		Same
Finance	Superannuation records	Close of financial year	10 Years	Review and if no longer needed destroy		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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.	Same
Legal, Complaints & information Rights	Fraud case files	Case closure	6 years	Review and if no longer needed destroy		Same
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.	Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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		New
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.	Same
Legal, Complaints & information Rights	Litigation records	Closure of case	10 years	Review and consider transfer to a Place of Deposit		Same

Broad descriptor	Record Type	Retention Start	Retention period	Action at end of retention period	Notes	New/ Change/ Same
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 Place of Deposit		New
Legal, Complaints & information Rights	Software licences	End of lifetime of software	Lifetime of software	Review and if no longer needed destroy		Same
Legal, Complaints & information Rights	Subject Access Requests (SAR) and disclosure correspondence	Closure of SAR	3 Years	Review and if no longer needed destroy		Same
Legal, Complaints & information Rights	Subject access requests where there has been a subsequent appeal	Closure of appeal	6 Years	Review and if no longer needed destroy		New