East Lancashire Hospitals NHS Trust

TRUST WIDE DOCUMENT

Delete as appropriate	**Policy**
DOCUMENT TITLE:	**CLINICAL RECORDS POLICY**
DOCUMENT NUMBER:	**ELHT/C013 Version 5.2**
DOCUMENT REPLACES Which Version	**Version 5.1**
LEAD EXECUTIVE DIRECTOR DGM	Director of Finance, Information & Planning (SIRO)
AUTHOR(S): Note should not include names	Directorate Manager Centralised Outpatients & Administration Services

TARGET AUDIENCE:	All Trust Personnel
DOCUMENT PURPOSE:	The Clinical Records Policy sets out the standards required for clinical record keeping, and details the specific requirements relating to health records management within the organisation to ensure the delivery of an effective high quality clinical records service. This policy also sets out the current legislation relating to health records.
To be read in conjunction with (identify which internal documents)	

SUPPORTING REFERENCES	• Records Management Code of Practice for Health and Social Care 2016Academy of Medical Royal Colleges – A Clinician's Guide to Record Standards • Care Quality Commission the right information in the right place at the right time (2009) • An organisation with a memory (2000) • Confidentiality : NHS code of practice (2003) • NHS information governance: guidance on legal and professional obligations (2007) • Information security management: NHS code of practice (2007) • A question of balance: independent assurance of information governance returns(2010) • Information governance toolkit • Nursing and midwifery council (2009) Record Keeping: guidance for nurses and midwives • Department of Health (2010) Essence of care benchmarking for record keeping • Royal College of Physicians (2008) a clinician guide to record standards part 1 & 2 • Royal College of Physicians (2009) generic medical record keeping standards

CONSULTATION		
	Committee/Group	**Date**
Consultation	Health Records Steering Group reports to Quality & Safety Board	January 2017
Approval Committee	Governance Committee	
Ratification date at Policy Council:	January 2017	
NEXT REVIEW DATE:	January 2018	
AMENDMENTS:	V5 - Policy updated to reflect inclusion of community records following transfer of community services. V5.1 – Policy updated to reflect titles/meetings changes V5.2 – Policy updated to reflect the introduction of the Information Governance Alliance, Record Management Code of Practice for Health and Social Care 2016 following the withdrawal of the DOH Records Management Code of Practice Parts 1 & 1. Title changes Approval of clinical documentation within the Trust Inclusion of the HRSG Terms of Reference	

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Appendices

CLINICAL RECORDS POLICY

1. Objectives of this Policy

The key objective of this policy is to ensure that a comprehensive and secure clinical records management system is in place in the Trust, and that there is a process for managing the risks associated with clinical records in all media. This policy sets out the duties, standards, managerial responsibilities and minimum retention periods for the effective management of all clinical records. This includes the creation, day to day use, storage, and maintenance and disposal procedures.

Clinical records include all clinical information relating to a patient in whatever media this is available. These may include:

- Electronic or paper-based patient health records including all specialties
- Urgent care and emergency, birth and all other registers;
- Theatre records and related registers;
- Radiology and imaging reports, output and images;
- Photographs, slides and other images;
- Audio and video tapes, cassettes, CD-ROMs
- Computerised records

Clinical Records may be referred to as:

- Medical records
- Patient records/notes
- Speciality/departmental records or assessments
- Casenotes
- Health records
- Obstetric health records
- Urgent care and emergency card

They inform the clinician of all key features which might influence the treatment proposed. They also provide a contemporaneous and complete record of the patient's treatment and related features.

In addition to ensuring good patient care, complete, accurate and timely records allow a clear picture of events to be obtained, which is imperative for managing claims and complaints, and for auditing practice and remaining proactive.

2. Duties and Accountability

2.1. Chief Executive

The Chief Executive is accountable for the quality of records management within the Trust and exercises this responsibility through delegation to the Director of Finance Information and Planning as Senior Information Risk Officer (SIRO) and via line management to the Director of Diagnostics and Clinical Support Division.

2.2. Directorate Manager, Centralised Outpatients & Administration Services

The Directorate Manager for Centralised Outpatients & Administration Services reports via the Clinical Director for Centralised Outpatients and Administration Services to the responsible Executive Director. She/He will be the organisational lead manager responsible for Clinical Records management, and act as the Information Asset Owner (IAO) for all patient records within the Trust. She/He will facilitate the Health Records Steering Group, and will be responsible for providing exception reports where appropriate to the Patient Safety & Risk Committee. She/He will act as the lead for maintaining and updating the Clinical Records action plan.

2.3. Executive Directors and Divisional Management Teams

They must ensure that:-

- All staff adhere to the policy
- The policy and procedures are carried out for records consistently and appropriately.
- Record keeping standards are monitored through quality control and audit to ensure the effectiveness of the policy
- Appropriate training is given for staff to understand and comply with their responsibilities

2.4. Individual responsibility

All healthcare workers are professionally accountable for maintaining clinical records as defined in this policy. All staff are responsible for any record they create or use, and any records which are created are public records. All staff that come into contact with patient information have a personal common law duty of confidence. Any records identified as lost or missing must be reported as an incident. Any breach of confidentiality will result in consideration of disciplinary action.

2.5 Health Records Steering Group

The Health Records Steering Group is responsible for the implementation and development of the clinical records policy, and to oversee the audit and monitoring of its implementation and action recommendations. The steering group is required to report via its minutes and exception reports to the Patient Safety & Risk Committee which is the overarching operational group for risk management in the Trust

2.6 Quality & Safety Board

The Patient Safety & Risk Committee will receive assurance on progress with the clinical records action plan(s) via the minutes of the Health Records Steering Group, and exception reports on specific issues or concerns from the Health Records Steering Group.

2.7 Clinical Audit

The Clinical Audit and Health Records Departments will undertake the audits as required and will provide these to the Health Records Steering Group for review and production of an action plan.

2.8 Services Records Audit

All Services will be required to audit their clinical records for compliance with this policy and these will be submitted to the Health Records Steering Group for review and production of an action plan.

3. Legal Obligations that apply to records

The main legislative measures that give rights of access to health records include:

- Data Protection Act 1998: gives rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf.
- Access to Health Records Act 1990 – gives rights of access to deceased patient health records by specified persons.
- Medical Reports Act 1988 – gives rights for individuals to have access to reports relating to themselves, provided by medical practitioners for employment or insurance purposes.

3.1. Data Protection Act 1998

This act regulates the processing of personal data held manually and on computer. It applies to personal information generally not just health records. The Act contains three strands:

1. Notification by a data controller to the Information Commissioner
2. Compliance with the 8 data protection principles
3. Observing the rights of data subjects

Patient Access to Records

The Data Protection Act gives the right of individuals, or their authorised representative to seek access to their records. This must be completed within a 40 calendar day timescale. There are two main exemptions:

1. If the record contains third party information

2. If access to all or part of the record will seriously harm the physical or mental well- being of the individual or any other person.

Patient access requests must be made to the Access Request Clerks in the Health Records Department, Burnley General Hospital, Burnley or appropriate department.

Subject Access Regulations sets out the fees a patient may be charged to view their records or to be provided with a copy of them. The maximum fee that can be charged for providing copies of health records is £10 for computer records and £50 for copies of manual records or a mixture of manual and computer records, including postage and packaging costs. Patients are also entitled to apply to see their records at no cost if they have been seen in the last 40 calendar days (where no copy is required). Where an ongoing complaint is being managed within the organisation consideration will be given to these being provided at no cost.

3.2. Access to Health Records Act 1990

The Access to Health Records Act now only affects the health records of deceased patients. It applies only to records created since 1 November 1991. The Act gives access to:

- the deceased's personal representatives (both executors or administrators) to enable them to carry out their duties: and
- anyone who has a claim resulting from the death.

However, this not a general right of access, it is a restricted right and the following circumstances could limit the applicant's access:

- if there is evidence that the deceased did not wish for any or part of their information to be disclosed; or
- if disclosure of the information would cause serious harm to the physical or mental health of any person; or
- if disclosure would identify a third party (i.e. not the patient nor a healthcare professional) who has not consented to that disclosure.

As with the Data Protection Act, a medical professional may be required to screen the notes before release.

Under the Act, if the record has not been updated during the 40 calendar days preceding the access request, access must be given within 21 days of the request. Where the record concerns information all of which was recorded more than 40 calendar days before the application, access must be given within 40 calendar days, however, the Trust will endeavor to supply the information within 21 days.

A fee of up to £10 may be charged for permitting an applicant to view a record that has not been added to in the proceeding 40 calendar days before the date of the application. No fee may be charged for viewing a record if they have been amended or added to in the last 40 calendar days.

Where a copy is supplied, a fee not exceeding the cost of making the copy may be charged. The copy charges should be reasonable, as the doctor or Trust may have to justify them. If applicable, the cost of posting the records may also be charged.

3.3. Data Protection Order 2000 (processing of sensitive personal data)

This order amends the DPA 1998 and provides that sensitive personal data (for example information relating to physical or mental health) may be lawfully processed without explicit consent where there is a substantial public interest in disclosing the data for any of the following purposes:

- for the detection and prevention of crime;
- for the protection of members of the public against malpractice, incompetence, mismanagement etc.;

Access covers the right to obtain a copy of the record in permanent form, unless the supply of a copy would involve disproportionate effort or the individual agrees that his/her access rights can be met some other way, for example by viewing the record.

Access must be given promptly and in any event within 40 calendar days of receipt of the fee and request. If the application does not include sufficient details to identify the person making the request or to locate the information, those details should be sought promptly and the 40-day period begins when the details have been supplied.

However, the Secretary of State has issued guidance stating that healthcare organisations should endeavor to meet such requests within a 21-day timescale. This is so that Data Protection Act access rights reflect the previous rights contained within the Access to Health Records Act 1990.

3.4. NHS Trust Sexually Transmitted Diseases Directions 2000

Every NHS Trust must take all necessary steps to ensure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except:

- For the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof; and
- For the purpose of such treatment or prevention.

3.5. Common Law Duty of Confidentiality

The general rule is that information cannot normally be disclosed without the patient's consent. There are exceptions to this rule

- where disclosure is in the public interest, and
- where there is a legal duty to do so, for example a court order

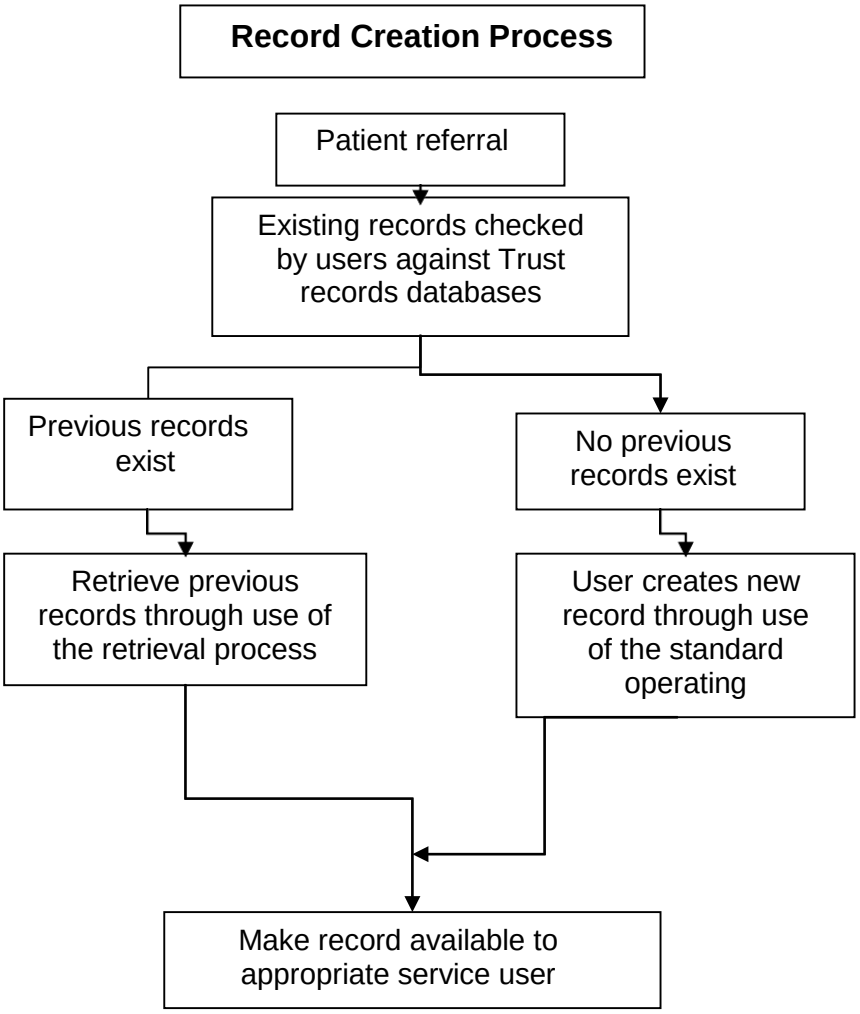
All such requests must be made to the Health Records Manager, Head of Patient Administration or Caldicott Guardian.

4. Creating records

Patient records should be created and aligned to the Trust's Acute Patient Administration System and/or the Community Patient Administration System. These records must include the Trust's Patient Administration System unique reference number and/or the patient's NHS number. These two systems are the master source of information for patient activity within the Trust.

All records created within the Trust should be arranged in a record keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information. Records may be retained in paper or electronic format but the same referencing system must apply.

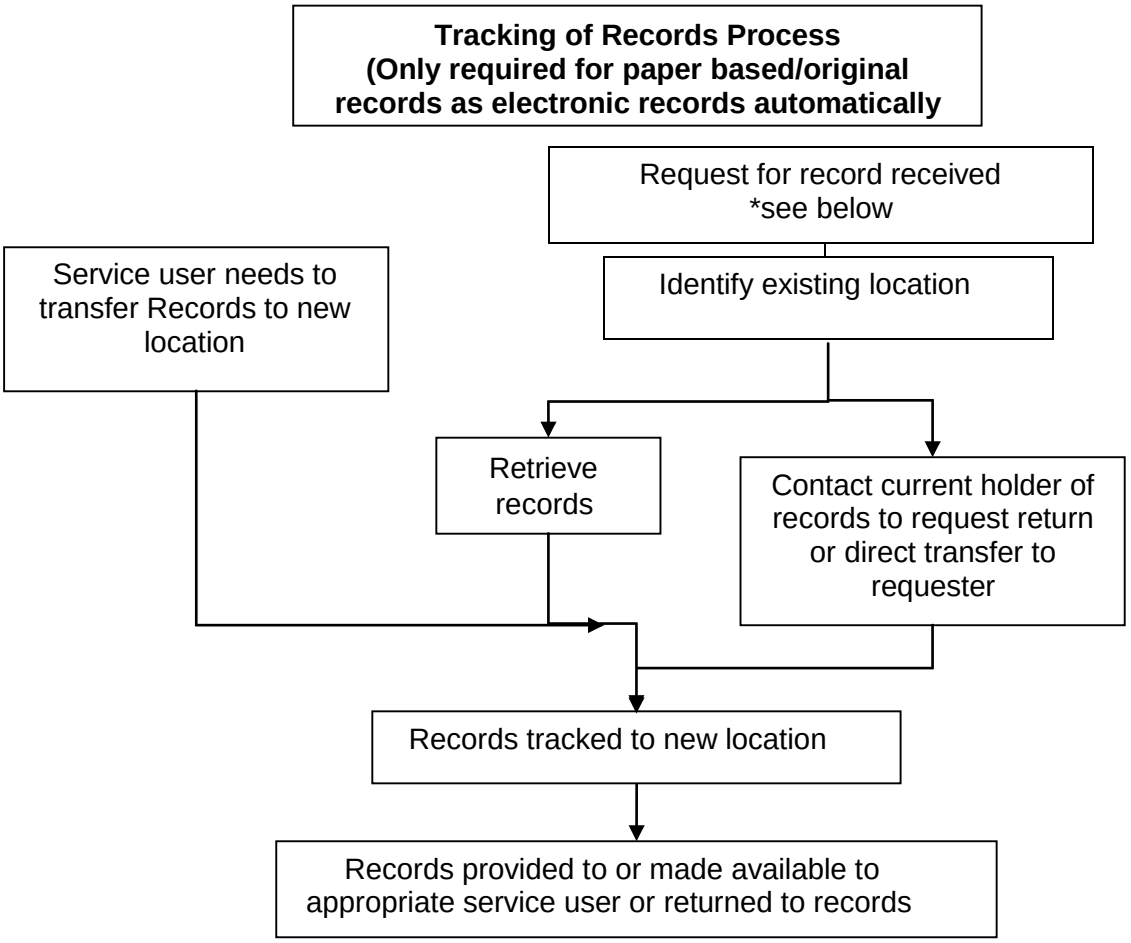
Process for Creating Records – How a new record is created



5. Tracking Records

The movement and location of records must be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions. Record tracking is only applicable to paper and other original records.

Process for tracking records



***Casenote tracking system**

6. Casenote Tracking System

The PAS system is used to electronically track patient casenotes. This enables Trust staff on all hospital sites to accurately identify the physical location of Casenotes and track their movements through the transfer facility within the casenote tracking (CNT) functionality.

Following a request made to the appropriate records library or department by telephone/email/writing. The staff receiving the request for records must establish that the person making the request has the authority to view the record and is only doing so with good cause. Unavailability of casenotes for clinic or inpatient attendance presents a clinical risk to the patient and therefore must be avoided wherever possible. The ward / department of residence will be the tracked location. Casenotes for patients going to theatre, x-ray or other diagnostic service will not require tracking as they will remain with the patient or escort.

No other method of tracking should be used for casenotes. If PAS is unavailable the Health Records Department must be contacted and Business Continuity Plans will be implemented in accordance with Emergency Planning.

Authorised Borrowers

It is the responsibility of all Managers to ensure that staff input the relevant Casenote Tracking information in order to maintain a comprehensive and up to date system. This includes keeping the details of Authorised Borrowers up to date. Managers have full responsibility for ensuring that the list of Authorised Borrowers associated with their area of work is reviewed and kept up to date. The relevant updates and changes must then be forwarded to the Assistant Health Records Manager based at Royal Blackburn Hospital (RBH) on a monthly basis.

Storage Locations

It is the responsibility of all Managers to ensure that staff input the relevant casenote tracking information in order to maintain a comprehensive and up to date system. This includes keeping the details of current Storage Locations up to date including off-site storage. Managers have full responsibility for ensuring that the list of storage locations associated with their area of work is reviewed and kept up to date. The relevant updates and changes must then be forwarded to the Deputy Health Records Manager based at Royal Blackburn Hospital (RBH) on a monthly basis.

Loaning of Casenotes to Authorised Borrowers

Health Records library staff will be responsible for the completion of the loan case note information. Library staff must complete the loan date and expected return date associated with each individual set of casenotes. Library staff will also enter the requesting authorised borrower details and storage location details of the casenotes.

Returning of Casenotes to Main Storage Location

The authorised borrower of a casenote is responsible for transferring the casenotes back to the main storage location before or on the expected return date. Notes must not be kept in authorised borrowing storage locations for more than 4 weeks, unless the patient is expected to return to the clinic/ward within a 1 week period. The authorised borrower must return the casenotes to a transit location. Library staff will then return the physical casenotes to a specified storage location within the health records libraries/Off-site storage location. Health Records staff will be responsible for ensuring the casenotes storage location is updated once the physical casenotes are received and filed.

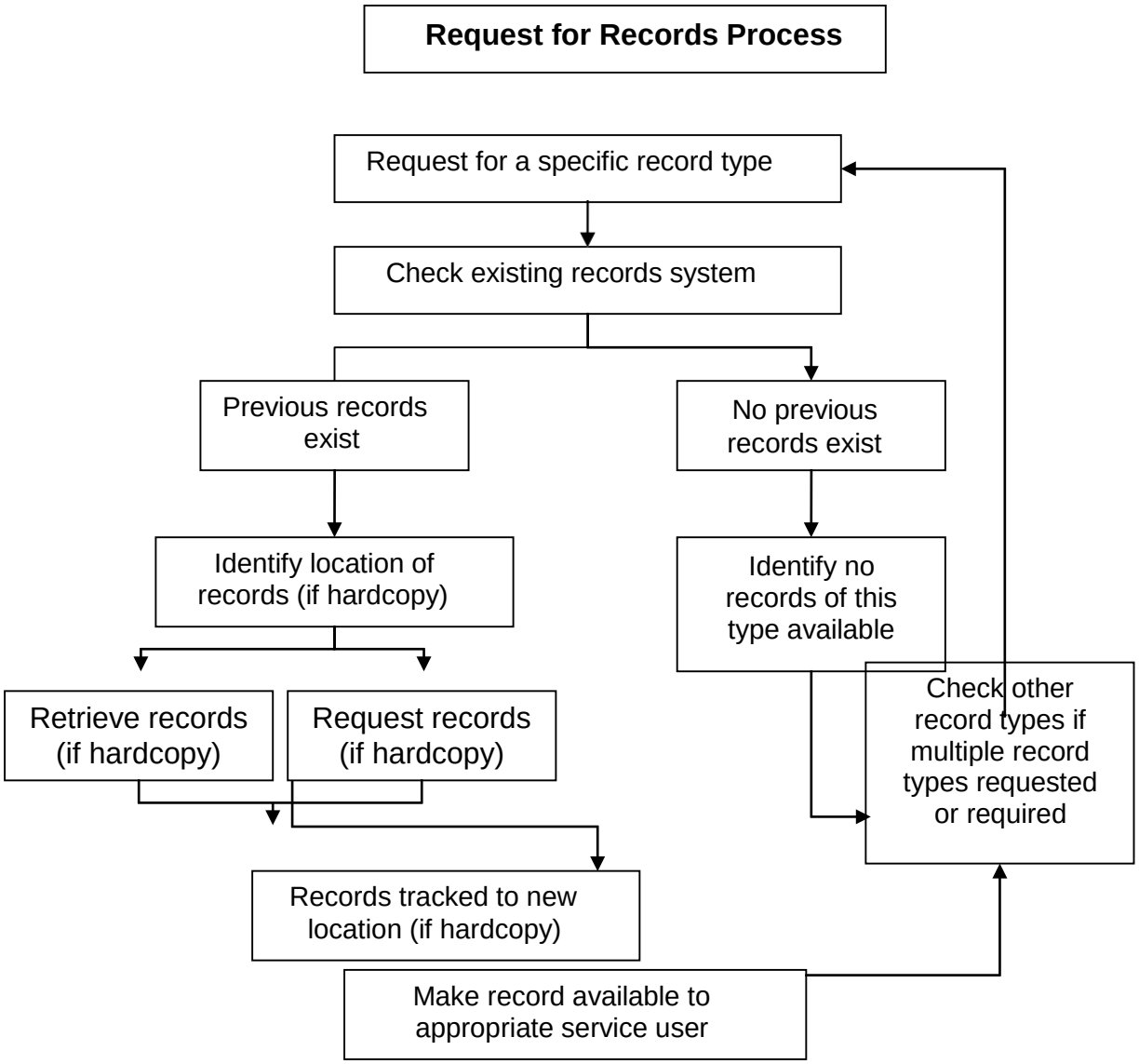
All staff are responsible for the maintenance of comprehensive and orderly casenotes whilst in their care. This means that all loose filing, nursing notes, discharge letters and reports must be filed inside the casenote folder, in the appropriate order at the point of care.

7. Retrieving Records

The record keeping system, where paper or electronic, should include a documented set of rules for referencing, titling, indexing and if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information when it is needed and to maintain security and confidentiality.

Digital information must be stored in such a way that throughout the lifecycle it can be recovered in an accessible format in addition to providing information about those who have accessed the record.

Process for Retrieving Records



8. Systems for Alerting

Each paper record must allow for the provision of a system to alert clinicians to all identified allergies and alerts recorded on the hospital casenote.

In the event that allergies and alerts are identified in departmental record systems, these must then be recorded in the hospital casenote if one exists.

Each individual system/departmental record should have a documented approach for recording its activities, including creation, retrieval, tracking, retention, disposal and destruction of the records created.

For hospital based inpatient and outpatient and emergency care records, where the acute Patient Administration System and the Electronic Patient Tracking Systems are the main reference systems, the hospital casenote and emergency card will be the main record source.

Speciality records may be held locally to support local clinical protocols where close access is required to a patient's treatment notes eg obstetrics, orthodontics, physiotherapy. Other departments/ areas where records are created must hold their own documented approach detailing the operational policies for the management of their clinical records.

9. The Five Basic Record Keeping Standards required by the Trust to be used by all staff - as a minimum the Trust requires all staff to adhere to the following basic records keeping standards.

1. A unique patient identifier must be used in all records.
2. All entries must be made in chronological order, or if written retrospectively this must be noted – electronic records show timelines and chronology in summary
3. All entries must be written in black ink (does not apply to electronic records)
4. All entries must be signed, and dated or listed to a chronological identifiable date. For electronic records a unique login or e-signature are accepted.
5. All alterations must be made in a way so that the original documentation and alteration are clear and all alterations must be signed and dated.

10. Good Practice Guidelines

In order to provide comprehensive accurate and clear records, staff should conform to their professional guidelines eg.

- Keep clear, accurate and legible records, reporting the relevant clinical findings, the decision made, the information given to patients, and any drugs prescribed or other investigation or treatment.
- Make records at the same time as the events you are recording or as soon as possible afterwards.
- Only use abbreviations that follow common conventions.
- Accurately date and time records using the 24 hour clock.
- Do not use meaningless phrases, irrelevant speculation, offensive subjective statements or irrelevant personal opinions regarding the patient/service user.

(Ref: Academy of Medical Royal Colleges – A Clinician's Guide to Record Standards)

11. Contemporaneous record

Following the retrieval, receipt and completion of records into a clinical care document, the clinical record should reflect the continuum of patient care and should be viewable in chronological order.

In operational areas records may be divided and current records filed in ring binders. These are acceptable as long as they are filed in chronological order in the patient's main record following discharge. Recording of information held in one part of the record does not have to be duplicated.

12. Retention, Disposal and Destruction

12.1. Retention

The Trust will use as a minimum the Department of Health's Records Retention Schedule (Appendix 2 Related to Health Records). This appendix details the minimum retention period for each type of health record issued by the NHS Code of Practice for Records Management.

Clinical records may be retained for permanent preservation, or retained for research or litigation purposes. A formal request must be made by letter or email by the person wishing to retain a record to all record holders on the approved list (see appendix 3). This requirement will be recorded on all existing clinical records and on the relevant PAS system if one is available to ensure that these records are not destroyed.

Electronic records will be retained in line with the retention schedule and must be stored in such a way that throughout the lifecycle it can be recovered in an accessible format. Retention periods will be reviewed and maintained by the Health Records Steering Group.

12.2. Disposal

All documents must be reviewed annually in accordance with the Trust's clinical records retention schedule.

Where records are identified for archival interest, the Directorate Manager must be contacted who will arrange for transfer of custody of these records to the National Archives.

The decision on the transfer of records from paper to electronic and the subsequent destruction of the paper record will be made by the Health Records Steering Group/E-health programme board.

All records which have been archived electronically must be readable and referenced on the appropriate system. Access can be obtained to these records by contacting the appropriate department.

12.3. Destruction

Documents must be destroyed confidentially either by use of a local shredder or using the approved confidential waste removal contractor.

Where records are destroyed by an external company, eg approved storage companies, a record of the destruction of the records showing their reference, description and date of destruction must be received and retained by the service.

13. Records Security and Storage

All staff are responsible for the safe-keeping of all records which they handle. When out of file all records must be kept secure at all times and all offices where records are stored must be locked. It is the responsibility of each departmental manager to ensure appropriate access is available to any records required out of hours. A privacy impact assessment should be conducted on the offsite storage providers.

14. Records Security Standards

1. Clinical records contain confidential information, and it is therefore vital that confidentiality is safeguarded at every stage of the lifecycle of the record.

2. Clinical records must only be accessed for clinical purposes, approved research protocols, clinical audit, complaints investigation and litigation.

3. Original records should not be sent to any other organisation without prior approval.

4. Clinical records transferred by hospital employees, must be placed in a sealed envelope or approved system for secure transportation.

5. Clinical records transferred by non-hospital employees must be undertaken by appropriate approved systems or contractors and should be transferred in sealed and tamperproof containers/envelopes.

6. Staff taking clinical records off premises must accept responsibility for their safe keeping maintaining confidentiality.

7. Handheld records must be retrieved from the patient/service at the last contact. Systems must be in place for staff to obtain the handheld record from the patient following treatment.

8. All staff who use clinical records must be fully aware of their personal responsibilities and undertake regular training. (see Information Governance Toolkit and the Information Governance policy)

9. Records identified as lost or missing must be reported immediately to your line manager and if still identified as missing via an Incident report form. The Health Records department should be contacted for advice on further actions.

10. In the unlikely event that records are identified as sent to the wrong address all

reasonable methods of recovering these documents must be made. This will include contacting the postal service provider, or courier, and must include consideration of a staff member(s) going to the address to recover the information in person. Reasons for not undertaking any actions must be documented on the incident investigation section of the incident report.

15. Training and Development

Training on Record Keeping is mandatory for all Trust staff. This is included in the Information Governance Toolkit for all Trust staff and reflected in Trust Policy (HR42), monitoring of this is audited in Mandatory Training policy.

Record keeping guidance is available for reference in all services/wards, and regular updates on clinical records issues are provided via message of the day and departmental/Information Governance newsletters.

16. Process for Monitoring Compliance of this Policy

The effective implementation of this policy will be monitored through a process of internal audits. These audits will be undertaken regularly to ensure compliance with this policy. See appendix 2 for the audit schedule.

The audit reports will as a minimum include:-

- methodology
- findings
- recommendations
- action plan

The outcome of all records audits will be reported to the Health Records Steering Group who will agree the action plan and include actions in the Trust Clinical Records Action Plan. The Health Records Steering Group will monitor this plan to ensure that all recommendations have been actioned appropriately.

All audit reports submitted to the Health Records Steering Group will be reviewed at least once each calendar year to monitor whether the format for audit reports has been achieved. This audit will be presented to the Health Records Steering Group and will monitor whether actions plans have been reviewed. If any deficits are identified, the Trust's clinical records action plan will be updated accordingly.

The Health Records Steering Group is a sub group of the Patient Safety & Risk Committee where all risks are monitored – see Appendix one for Terms of Reference.

17. Introduction/Revision of Clinical Documentation for inclusion in the hospital record

- Trust Wide Clinical Documentation used in more than one Division requires approval at the HRSG
- Specific Divisional Clinical Documentation only requires approval at the Divisional Quality and Safety Board

Appendix 1 HEALTH RECORDS STEERING GROUP TERMS OF REFERENCE

AIMS AND OBJECTIVES:

- To ensure the provision of a high quality Health Records Service for the Trust and the wider Health Community.

- To facilitate and support the development of the Electronic Health Record Trust-wide and manage transition to paper electronic.

TERMS OF REFERENCE:

1. Facilitate continuity of care by the effective and efficient transmission of information between Clinicians using the health record regardless of the media on which it is held.

2. Monitor the Health Records Service to ensure that the overall objectives of the Trust and the wider Health Community are met and that the Trust complies with professional good practice, current legislation, national policies and guidelines.

3. Develop policies and procedures relating to the Health Records Service, regularly review those policies and amend them as appropriate and ensure that all staff are aware of the policies and procedures and that appropriate training is provided.

4. Develop, implement and regularly monitor and manage standards for the Health Records Service and ensure that compliance with the standards is reported regularly to the Trust Board.

5. Set standards for health records documentation including casenote architecture and documentation for inclusion in the casenote, and work in conjunction with Divisions and Directorates to promote safe personal and effective case note provision.

6. Ensure that Health Records audits are undertaken on a regular, systematic basis and that action plans are generated and approved. Forward any unresolved issues to the DQSB Boards.

7. Support the development of multi-disciplinary records in both paper and Electronic Health Record.

8. Support the Health Records Service and Clinical Divisions on a continuing basis to ensure compliance with NHSLA Records Management standards.

MEMBERSHIP:

Consultant - Chair
Directorate Manager - Centralised Outpatients and Administration Services (Convenor)
Divisional Directors to nominate representatives from each specialty
Health Records and Outpatient Reception Manager
Divisional Governance Leads
Medical Secretaries Representative
Ward Clerk Representative
Head of Information Governance

Chief Clinical Information Officer
Chief Nurse Information Officer
Four Outpatient Representatives
Four Inpatient Representatives
Clinical Audit Manager
Representative from Quality and Safety Group

FREQUENCY OF MEETINGS
Minimum of quarterly

QUORUM
25% of members of which Chair, Health Records Representative, 1 Divisional Governance Lead, 1 Clinical Representative and 1 Governance/Quality and Safety Representative need to be present.

REQUIRED FREQUENCY OF ATTENDANCE
100% of meetings which would include attendance by nominated deputy.

DISTRIBUTION OF MINUTES
All members of the group
TQSB
Minutes archived on V Drive in Health Records Steering Group folder.

PROCESS FOR MONITORING EFFECTIVENESS
Via Trust Quality and Safety Board Monitoring

REPORTING ARRANGEMENTS FROM SUB COMMITTEES
Health Records User Group
E Health Board

REPORTING ARRANGEMENTS TO:
The Health Records Steering Group will report to the Trust Quality and Safety Board

Appendix 2 CLINICAL RECORDS AUDIT SCHEDULE

STANDARD	MONITORING PROCEDURE	DOCUMENTATION AVAILABLE	WHO	MINIMUM FREQUENCY
Legal Obligations	Monitor the subject access request procedure	Datix subject access report	Access Clerks/Datix Reporting	Once every calendar year
Creating Records	Casenotes - sample audit of 30 new casenotes will be checked against the Patient Administration System to ensure data and record is correct	Creating Records Checklist New casenotes	Health Records Manager	Once every calendar year
Records Tracking	Casenotes - A Casenote Tracking Audit will be undertaken annually reflecting all Clinical Divisions. A minimum of 100 casenotes will be selected across all sites. Casenotes will be checked against PAS to establish that they are appropriately tracked. The audit will identify if borrowers are returning casenotes within agreed timescales.	Casenote Tracking Audit Reports	Health Records Manager Reports to Health Records Steering Group	Once every calendar year
Disposal & Destruction Audit	Casenotes - An Audit of casenotes for disposal will be undertaken to see that records due for disposal in the preceding year were disposed of and whether a record of disposal showing the reference description and date was maintained in accordance with the policy requirements.	Retention & Disposal Audit including disposal certificate	Health Records Manager	Once every calendar year
Scanned Documentation	Casenotes – An Audit will be undertaken annually on archived records to check that these have been recorded on PAS. A minimum sample of 30 scanned records will be checked against PAS.	Scanned Documentation Audit	Health Records Manager	Once every calendar year

STANDARD	MONITORING PROCEDURE	DOCUMENTATION AVAILABLE	WHO	MINIMUM FREQUENCY
Retrieval Availability Audit	Casenote Retrieval Availability audits will be performed for all patients attending outpatient clinics. This will be recorded on PAS as part of clinic reception function. Clinical audit will sample audit elective and emergency admissions	PAS Record Casenote Availability Audit reports	Outpatient Information Staff Clinical Audit Departmental Records Leads	Once every calendar year (Monthly availability reports will be produced for monitoring purposes)
Recent Care Documentation & Basic Record Keeping Audit	Multi -professional clinical audit on casenotes	Recent Care /Basic Record Keeping Proforma	Clinical Audit Departmental Records Leads Reports to Health Records steering Group	Once every calendar year
Electronic Records Audit	Data will be extracted from 200 electronic records from both interfaced and non-interfaced systems and mapped back to PAS	Electronic Records Audit proforma	Clinical Audit Department	Once every calendar year
Audit on Records Management Audits	All audits submitted to HRSG are monitored to ensure they are compliant with Trust policy	Audit compliance in Trust policy	Head of Patient Administration	Once every calendar year
Casenote Compliance	Quality assure by checking sample of 50 casenotes for compliance. This will include single numbering system, merger of casenotes, and existence of Alert sheets.	Casenote Compliance Checklist Audit	Health Records Department	Once every calendar year
Casenote Archive Volume Management	Sample audit on 25 archived casenotes to quality assure Trust policy on archive volume management	Volume Management Checklist Audit	Health Records Department	Once every calendar year
Ward Casenote Storage Audit	Clinical Audit to sample ward storage systems for casenotes	Ward Storage Audit Form	Clinical Audit Department	Once every calendar year

Appendix 3 - Health Records Retention Schedule

This retention schedule details a **Minimum Retention Period** for each type of health record. Records may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. Where a period longer than 30 years is required eg. to be preserved for historical purposes or for any pre-1948 records, the Health Records Manager should be informed who will contact the National Archives. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

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

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound, and including all records of NHS patients treated on behalf of the NHS in the private healthcare sector):

- patient health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident & Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (ie microfiche/microfilm);audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents.

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

Notes

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

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

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

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

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
personal health record – patient-held record)				
Audio tapes of calls requesting care (PCT, GP, NHS Direct Records etc)	Retain taped calls for 3 years providing all relevant clinical information has been transferred to the appropriate patient record. Where the information is NOT transferred into a health record, the tapes should be retained for 10 years.	Limitation Act 1980	Destroy under confidential conditions	N
Audiology records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Audit Trails (Electronic Health Records)	NHS organisations are advised to retain all audit trails until further notice.		Destroy under confidential conditions	N
Autopsy records – see Post mortem records and registers				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Birth registers (ie register of births kept by the hospital)	Lists sent to General Register Office on a monthly basis. Retain for 2 years		Likely to have archival value. See note 1	S
Birth Notification (to Child Health Department)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, **or** 8 years after death.		Destroy under confidential conditions	N
Blood transfusion records (see pathology records)				
Body release forms	2 years		Destroy under confidential conditions	S
Breast screening X-rays (see Mammography Screening)				

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
records relating to children and young people)	after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period		conditions	
Clinical audit records	5 years		Destroy under confidential conditions	S
Clinical Protocol (GP, in-house)	25 years		Destroy under confidential conditions	N
Clinical psychology	20 years		See note 1	C
Clinical trials (see research records)				
Contraception and Sexual Health Records (Including where a scan is undertaken	8 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
prior to termination of pregnancy but the patient goes elsewhere for the procedure)	HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years		
Controlled drug documentation (Moved from Pharmacy Records)	Requisitions – 2 years Registers and CDRBs – 2 years from last entry Extemporaneous preparation worksheets – 13 years Aseptic worksheets (adult) – 13 years Aseptic worksheets (paediatric) – 26 years External orders and delivery notes – 2 years Prescriptions (inpatients) – 2 years Prescriptions (outpatients) – 2 years Clinical trials 5 years minimum (may be longer for some trials) Destruction of CDs – 7 years Future Regulations may increase the period of time for the storage of records. Please refer to Department of Health http://www.dh.gov.uk/en/index.htm and Royal Pharmaceutical Society of Great Britain http://www.rpsgb.org.uk/ websites for up-to-date information	Misuse of Drugs Act 1971 Misuse of Drugs Regulations 2001 Safer management of controlled drugs: a guide to good practice in secondary care (England). October 2007, Dept of Health, 17th October 2007 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079618	Destroy under confidential conditions	N
Counselling records	20 years **or** 8 years after the patient's death if patient	Guidance for best practice: the	See note 1	C

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
register of deaths kept by the hospital, where they exist in paper format	Death registers prior to lists sent to GRO – offer to Place of Deposit		archival value. See note 1	
Dental epidemiological surveys	30 years		Destroy under confidential conditions	S
Dental, ophthalmic and auditory screening records including Orthodontic Records and Models	*Community Records* 11 years for adults For children 11 years or up to their 25th birthday, whichever is the longer *Hospital Records* Adult records – Retain for 8 years Children and young people – Retain until the patient's 25th birthday or26th if young person was 17 at conclusion of treatment, **or** 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period	British Dental Association	Destroy under confidential conditions	N
De-registered patients (received by PCT's) –	Records for de-registered patients, which are received by the PCT, should be retained for at least 10 years. After the retention period has elapsed a decision must be		Destroy under confidential	N

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

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
records)				
Duplicate patient record notification forms (NHS Direct)	2 years after the decision of whether or not to merge unless there is a business need to retain for longer.		Destroy under confidential conditions	N
Electrocardiogram (ECG) Records	7 years NB Each chart should be labelled with the patient's name and unique identifier. Any over-sized charts could then be stored separately where a report is written into the health records.		Destroy under confidential conditions	N
Endoscopy Records including: Sterilix Endoscopic Disinfector Traceability Strips, Traceability Stickers for PEG/Stents (Endoscopy)	Retain for standard retention periods i.e. 8 years for adults and in the case of children and young people retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, **or** 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period.		Destroy under confidential conditions	N
Family planning records (See also Contraception and	For records of adults – retain for 10 years after last entry For clients under 18 – retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare	Destroy under confidential conditions	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Sexual Health Records)	and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death	(FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years		
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	For post-mortem records which form part of the Coroner's report, approval should be sought from the coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) guidance from the Royal College of Pathologists and the Institute of Biomedical Science: http://www.rcpath.org.uk/resources/pdf/retention-SEPT05.pdf Human Tissue Act 2004	See note 1	S
Genetic records	30 years from date of last attendance	The Royal College of Pathologists endorses the Code of Practice and Guidance of the Advisory Committee on Genetic Testing (1997)	See note 1	S

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
GP records, including medical records relating to HM Armed Forces or those serving a period of imprisonment	GP Records, wherever they are held, other than the records listed below retain for 10 years after death or after the patient has permanently left the country unless the patient remains in the European Union. In the case of a child if the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions	S
	Maternity records – 25 years after last live birth	Limitation Act 1980, Congenital Disabilities (Civil Liability) Act 1976, Consumer Protection Act 1987	Destroy under confidential conditions	S
	Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983 –20 years after the date of the last contact; **or 10** years after patient's death if sooner NB GPs may wish to keep mental health records for up to 30 years before review. They must be kept as complete records for the first 20 years but records may then be summarised and kept in summary format for the additional 10-year period	Royal College of Psychiatrists	Destroy under confidential conditions	S
	Records relating to those serving in HM Armed Forces – The Ministry of Defence (MoD) retains a copy of the records relating to service medical history. The patient		Not to be destroyed. This refers to GP records of serving	S

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	until their 25th birthday		confidential conditions	
Homicide/'serious untoward incident' records	30 years		See note 1	S
Hospital acquired infection records	6 years		Destroy under confidential conditions	S
Hospital records (i.e. other non-specific, secondary care records that are not listed elsewhere in this schedule)	8 years after conclusion of treatment or death **Local Agreement – 10 years for live records** **8 years for deceased records**		Destroy under confidential conditions	N
Human fertilisation records, including embryology records	**Treatment Centres** The following retention periods apply to data held by clinics as established by HFEA Direction D 1992/1: 1. Where it is known that a birth has resulted from treatment – 25 years after the child's birth.	HFEA Data Protection Policy Version 2 Release Date 27/07/2007 http://www.hfea.gov.uk/docs/DP_Policy_-	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	2. Where it is known that no birth has resulted from treatment – 8 years after conclusion of treatment. 3. Where the outcome of treatment is unknown – 50 years after the information was first recorded.	_web.pdf		
	Storage centres Where gametes, etc have been used in research, records must be kept for at least, 50 years after the information was first recorded **Research centre** Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	Directions given under the Human Fertilisation and Embryology Act 1990, 24 January 1992 (this Act is subject to review by the Government: http://www.dca.gov.uk/StatutoryBars Report2005.pdf) This applies to centres in respect of information which they are directed to record and maintain under a treatment/storage licence.		S S
Human tissue (within the meaning of the Human Tissue Act 2004) (see Forensic medicine above)	For post mortem records which form part of the Coroner's report, approval should be sought from the Coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years		See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Immunisation and vaccination records	For children and young people – retain until the patient's 25th birthday or 26th if the young person was 17 at conclusion of treatment All others retain for 10 years after conclusion of treatment		Destroy under confidential conditions	S
Intensive Care Unit charts	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Joint replacement records	10 years For joint replacement surgery the revision of a primary replacement may be required after 10 years and there is a need to identify which prothesis was used originally. There is only a need to retain the minimum of notes with specific information about the original prosthesis for the full 10 years	http://www.njrcentre.org.uk Consumer Protection Act (CPA) 1987 & Section 11A(3) Limitation Act 1980 (in accordance with Section 4 CPA)	See note 1	C
Learning difficulties – (records of patients with) NB Specific Learning Difficulty is where a person finds one	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's	Royal College of Psychiatrists	Destroy under confidential conditions	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
particular thing difficult but manages well in everything else	death if patient died whilst in the care of the organisation			
Learning Disabilities NB A general learning disability is not a mental illness – it is a life-long condition, which can vary in degree from mild to profound	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died whilst in the care of the organisation	Royal College of Psychiatrists	Destroy under confidential conditions	N
Macmillan (cancer care) patient records– community and acute	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Mammography Screening (mammograms and reports)	Normal Packet – *9 years after date of final attendance* Screen detected cancers – *Indefinitely* Interval Cancers – *Indefinitely* Interesting Cases – *Indefinitely* Research Cases – *15 years after date of final attendance*	BFCR(06)4 Royal College of Radiologists	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	Age Trial Cases – *9 years after date of final attendance* Deaths – *9 years after date of final attendance* Where product liability is involved – *11 years* NB Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record	Consumer Protection Act 1981		
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child	See Addendum 1 (*Joint Position on the Retention of Maternity Records*) devised by: British Paediatric Association, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting	Destroy under confidential conditions	S
Medical illustrations (see Photographs below)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	death if patient died while in the care of the organisation			
Mental Health Records – Child & Adolescent (includes clinical psychology records) not listed elsewhere in this schedule	20 years from the date of last contact, or until their 25th/26th birthday, whichever is the longer period. Retention period for records of deceased persons is 8 years after death.		Destroy under confidential conditions	N
Mentally disordered persons (within the meaning of any Mental Health Act)	20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, **or** 8 years after the death of the patient/client/service user if sooner NB Mental health organisations may wish to keep mental heath records for up to 30 years before review (local decision). Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. This retention period has been intentionally left flexible to allow organisations to determine locally in collaboration with clinicians which option to follow as some organisations have storage problems and are unable to retain for longer than 20 years. The records of all mentally disordered persons (within the	Mental Health Act 1983 and its successors Royal College of Psychiatrists	When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	meaning of the MH Act) are to be retained for a minimum of 20 years irrespective of discipline e.g. Occupational Therapy, Speech & Language Therapy, Physiotherapy, District Nursing etc) Social services records are retained for a longer period. Where there is a joint mental health and social care trust, the higher of the two retention periods should be adopted			
Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		May have archival value. See note 1	S
Midwifery records	25 years after the birth of the last child	*Midwives rules and standards* 05.04 (rule 9)	Destroy under confidential conditions	S
Mortuary registers (where they exist in paper format)	10 years		See note 1	S
Music therapy records	Retain for the period of time appropriate to the		Destroy under	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		confidential conditions	
Neonatal screening records	25 years		Destroy under confidential conditions	S
Nicotine Replacement Therapy (dispensed as smoking cessation aid)	2 years unless there are clinical indications to keep them for longer		Destroy under confidential conditions	N
Notifiable diseases book	6 years		Destroy under confidential conditions	S
Occupational health records (staff)	3 years after termination of employment unless litigation ensues (see Litigation)		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Health records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Control of Substances Hazardous to Health Regulations 2002 (reg. 24(3))	See note 1	S
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	See above (reg. 10(5))	See note 1	S
Personnel health records under occupational surveillance	40 years from last entry on the record	Ionising Radiation Regulations 1999 (reg. 11(3))	See note 1	S
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	See above (reg. 19(3)(a))	See note 1	S
Occupational therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after		Destroy under confidential conditions	S

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
			See note 1	
Orthoptic records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions	S
Paediatric records (see Children and young people above)				
Parent-held records (i.e. records for sick/ ill children being cared for at home by community teams NOT the records of	At the end of an episode of care the NHS organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve parent-held records. The records should then be retained until the patient's25th birthday, or 26th birthday if the young person was 17 at the conclusion of		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
newborn children. These records are NHS records that belong to clinical staff but which are held by the parent.	treatment, **or** 8 years after death			
Pathology records *Documents, electronic and paper records* Accreditation documents; records of inspections	10 years or until superseded	http://www.rcpath.org/resources/pdf/retention-SEPT05.pdf The retention schedules are under review by the Royal College of Pathologists – check RCP website for updates	Destroy under confidential conditions	S
Batch records results (relating to products)	10 years	Consumer Protection Act 1987		N
Blood gas results	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	death if patient died while in the care of the organisation			
Bound copies of reports/records, if made	30 years			S
Day books and other records of specimens received by a laboratory	2 calendar years			S
Equipment/instruments maintenance logs, records of service inspections	Lifetime of equipment			S
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years			S
External quality control records	2 years			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Internal quality control records (relating to products)	10 years	Consumer Protection Act 1987		S
Lab file cards or other working records of test results for named patients	2 calendar years			S
Near-patient test data	Result in patient record, log retained for lifetime of instrument			S
Pathological archive/museum catalogues	30 years, subject to consent			S
Photographic records	30 years where images present the primary source of information for the diagnostic process			S
Records of	2 calendar years			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
telephoned reports				
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record			S
Reports, copies Post mortem reports	6 months Held in the patient's health record for 8 years after the patient's death			S
Request forms that are not a unique record	1 week after report received by requestor			S
Request forms that contain clinical information not readily available in the health record	30 years			S
Standard operating	30 years			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
procedures (current and old)				
Specimens and preparations Blocks for electron microscopy	30 years			S
Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record			S
Foetal serum	30 years			S
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides – 10 years Residual tissue – kept as fixed specimen once frozen section complete			S
Frozen tissue or cells for histochemical or molecular genetic analysis	10 years			S

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Paraffin blocks	30 years and then appraise for archival value			S
Records relating to donor or recipient sera	11 years post transplant			S
Serum following needlestick injury or hazardous exposure	2 years			S
Serum from first pregnancy booking visit	1 year			S
Wet tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens	Human Tissue Act		S
Whole blood samples, for full blood count	24 hours			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Transfusion laboratories Annual reports (where required by EU directive)	15 years			S
Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records – copies may only be lodged on the health record with the Coroner's permission			S
Blood bank register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive N 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4ºC			S

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
FP10, TTOs, outpatient, private	2 years (Electronic Patient Records will eventually hold all details)		NB Inpatient prescriptions held as part of health record	N
Parenteral nutrition	2 years (Original valid prescriptions should be kept in patient's notes)			N
Unlicensed medicines dispensing record	5 years (Requirement of MHRA Guidance Note No. 14. Permanent record of batch details kept)	MHRA Guidance Note No. 14		N
Worksheets Raw material request and control forms	At least 5 years (Part of batch record, so product liability issues apply)			S
Resuscitation box	1 year after the expiry of the longest dated item	Applies only to repackaged items (e.g. ampoules separated from outer packaging)		S
Chemotherapy, aseptics worksheets,	5 years	Product liability extends up to 11 years after		S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
parenteral nutrition, production batch records	(Product liability extends this to 11 years after expiry)	expiry		
Paediatric	At least 5 years See Note 6, Appendix ii)	Product liability extends up to 28 years		S
Quality Assurance Environmental monitoring results	1 year after expiry date of products As electronic record – in perpetuity			S
Equipment validation	Lifetime of the equipment			S
Quality Control documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	Article 51(3) Directive 2001/83		S
Refrigerator temperature	1 year (Refrigerator records to be retained for the life of any product stored therein, particularly vaccines)			S
Standard operating procedures	15 years As electronic record – in perpetuity			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Orders Invoices	6 years See Note 4, Appendix ii)	Limitation Act 1980		S
Order and delivery notes, requisition sheets, old order books	2 years Current financial year plus one See Note 4, Appendix ii)			S
Picking tickets/delivery notes	3 months (i.e. a "reasonable period" – for verification of order only)			S
Ward pharmacy requests	1 year (Record of what was requested by ward pharmacist – unlikely benefit after 12 months)	Limitation Act 1980		S
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record) NB In the context of	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Psychotherapy Records	20 years **or** 8 years after the patient's death if patient died while in the care of the organisation	Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 NB "Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient's medical records or in a case-file….." These records are subject to the retention periods in this schedule	Destroy under confidential conditions	N
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		See note 1	S
Records of destruction of	Permanently	BS ISO 15489 (section 9.10)	See note 1	S

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Referral letters – where the appointment was cancelled by the patient before the referral letter was included in the patient record (i.e. before the clinic preparation process)	the reason(s) why the patient/client cancelled the appointment retain for 2 years after the date the appointment was cancelled. Where there is no letter or correspondence detailing the reasons for the patient not attending for their appointment that goes to the clinician that referred the patient/client. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation.		confidential conditions	
Research Records 1. Clinical Trials of Investigational Medicinal Products (CTIMPs)				N
Trial Master File (responsibility of Sponsor & Chief Investigator to ensure that documents are retained)	Five years after the conclusion of the trial	The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006 – sections 18 and 28.	Destroy under confidential conditions	**N**
Research Ethics Committee Records	An ethics committee shall retain all the documents relating to a clinical trial on which it gives an opinion for: (a) where the trial proceeds, at least three years from the	Governance Arrangements for NHS Research Ethics	Destroy under confidential conditions	**C**

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	conclusion of the trial: or (b) where the trial does not proceed, at least three years from the date of the opinion.	Committees (GAfREC)		
Trial Subject's Medical Files (Sponsor & Chief Investigator's responsibility to ensure retained)	Five years after the conclusion of the trial There should be a flag or divider in health records for documents pertaining to research indicating that the patient has been recruited to a clinical trial or other research		Destroy under confidential conditions	**C**
Marketing authorisation (holders must arrange for essential clinical trial documents (including case report forms) other than subject's medical files, to be kept by the owners of the data):	15 yrs after completion or discontinuation of the trial, **or** Two years after the granting of the last marketing authorisation in the European Community and when there are no pending or contemplated marketing applications in the European Community, **or** two years after formal discontinuation of clinical development of the investigational product.	COMMISSION DIRECTIVE 2003/63/EC (brought into UK law by inclusion in The Medicines for Human Use (Fees and Miscellaneous Amendments) Regulations 2003) – section 5.2(c).	Destroy under confidential conditions	**N**
Trial subject's medical files	Retain in accordance with applicable legislation and in accordance with the maximum period of time permitted by the hospital, institution or private practice NB Documents can be retained for a longer period, however, if required by the applicable regulatory requirements or by agreement with the sponsor. It is the responsibility of the sponsor to inform the hospital, institution or practice as to when these documents no		Destroy under confidential conditions	**N**

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	longer need to be retained.			
All other documentation pertaining to the trial (retention of documentation is the responsibility of the sponsor or other owner of the data) Final Report (responsibility of sponsor or subsequent owner's to retain documents)	Retain as long as the product is authorised. Five years after the medicinal product is no longer authorised.		Destroy under confidential conditions Destroy under confidential conditions	**N**
2. Data Collected in the Course of Research Data collected in the course of research	Retain for an appropriate period, to allow further analysis by the original or other research teams subject to consent, and to support monitoring by regulatory and other authorities.	Research Governance Framework for Health and Social Care – paragraph 2.3.5. Good Research Practice (MRC Ethics Series, 2000, updated 2005) – paragraph 5.2. Personal Information in Medical Research (MRC	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		Ethics Series, 2000, updated 2003) – chapter 7. Data Protection Act 1998 – Part IV, Section 33 (3).		
Risk Assessment Records	Retain the latest risk assessment until a new one replaces it.			N
Scanned records relating to to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation. NB Providing the scanning process and procedures are compliant with BSI's BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically once the casenotes have been scanned the paper records can be destroyed under confidential conditions.		Destroy under confidential conditions	S
School health records (see Children and young people)				

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Suicide – notes of patients having committed suicide	10 years		See note 1	S
Temporary Resident's Forms (GMS 3/99)	2 years NB Temporary GPs should maintain a record of episodes of treatment and diagnoses as well as sending a copy to the patient's normal GP		Destroy under confidential conditions	N
Transplantation records	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 30 years	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) Addendum 1	See note 1	C
Ultrasound records (eg vascular, obstetric)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Vaccination records (see Immunisation				

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Vulnerable Adults (records for)	Where a patient/client/service user is transferred from the care of one NHS or social care organisation to another, all relevant information must be transferred to the patients' health or social care record held at the receiving organisation and they should then be retained for the period of time appropriate to the specialty. Where a patient/client/service user is assessed by a health or social care professional including ambulance personnel and is identified as a vulnerable adult the professional should follow the protocols for dealing with vulnerable adults in their organisation.		Destroy under confidential conditions	N
Ward registers, including daily bed returns (where they exist in paper format)	2 years after the year to which they relate		Likely to have archival value. See note 1	S
X-ray films (including other image formats for all imaging modalities/diagnostics)	General Patient Records – 8 years after conclusion of treatment Children & Young People – Until the patient's 25th birthday, or if the patient was 17 at conclusion of treatment, until their 26th birthyday or 8 years after the patient's death if sooner. Maternity – 25 years after the birth of the child, including still births Clinical Trials – 15 years after completion of treatment Litigation – Records should be reviewed 10 years after	BFCR(06)4 – Royal College of Radiologists Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	the file is closed. Once litigation has been notified (or a formal complaint received) images should be stored until 10 years after the file has been closed. Mental Health – 20 years after no further treatment considered necessary or 8 years after death. Oncology – see Oncology Records	move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234		
X-Ray Referral/Request Cards	8 years providing there is a record in the patient's health record that a referral/ request was made for an x-ray	Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234		
X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	S
X-ray reports (including reports for all imaging modalities)	To be considered as a permanent part of the patient record and should be retained for the appropriate period of time			S

Based on Royal College guidance

Addendum 1: Principles to be Used in Determining Policy Regarding the Retention and Storage of Essential Maternity Records

British Paediatric Association

Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Joint Position on the Retention of Maternity Records

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

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

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

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

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

List of Maternity Records to be Retained

6. Maternity Records retained should include the following:

   6.1 documents recording booking data and pre-pregnancy records where appropriate;

   6.2 documentation recording subsequent antenatal visits and examinations;

   6.3 antenatal in-patient records;

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

   6.5 blood test reports;

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

6.7 drug prescription and administration records;

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