York Hospitals NHS Trust

Records Management Handbook

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Records Management Handbook Part 1
What is Records Management?

1.1 Why Records Management Matters

Records Management is now very important for the NHS. It underpins the NHS Information Governance framework. It is also a vital part of compliance with two major pieces of legislation – the Data Protection Act, 1998, and the Freedom of Information Act 2000. (See Records Management in the NHS, below, for more detail). It is also necessary in order to comply with other legislative provisions and directives, such as the new Environmental Information Regulations.

Every office and department in the Trust holds records. We constantly make records, and we all use records every day. They record decisions, events and processes within the Trust. We cannot function without them and we need to take them seriously.

Records come in different formats: paper records, electronic records, microfilm or fiche, cassettes, X-rays, photographs and slides.

The Trust holds a huge number of types of records. Clinical records relate to patients and administrative records relate to its business at all levels – from top to bottom.

1.2 The consequences of bad records management practice

If we don't manage our records we will not comply with Information Governance, and we will not be compliant with the Data Protection Act, the Freedom of Information Act, and other legislation and directives, such as the new Environmental Information Regulations.

Inaccurate or irrelevant records cause constant confusion, and they could even have serious or shocking clinical or legal consequences.

Poor organisation of records leads to inefficiency, wastes time, means poor communication and decision making across the Trust and it can also cause serious trouble if important or vital records cannot be readily located.

Poor storage of records wastes space and money and can cause a health and safety hazard. A lack of organisation means trivial records are kept longer than necessary. Uncontrolled clearouts can throw away important records and poor disposal of records takes huge security risks.

Without proper systems and rules in place, issues of confidentiality, particularly important for the NHS, can be breached readily or

unthinkingly by staff and by others. Carelessness with Trust records can have major financial, legal and even life threatening results and lead to bad publicity and serious penalties.

1.3 Your role in records management

Everyone makes, handles, stores or disposes of records in their working lives. This is not someone else's job.

Although we might deal with records to a greater or lesser extent, and we might see, create or handle either trivial or important records, we all need to be aware of the issues and we need to be trained in good practice.

1.4 Records management in the NHS

The following national initiatives and legislation are the context for Records Management in the NHS:

- The Public Records Act 1958 and 1967 classed all NHS records as public records and made Chief Executives and senior managers of all NHS bodies personally accountable for their management and safe keeping in their organisations. The Department of Health was made the liaison point between the NHS bodies and Public Record Office (now The National Archives)
- The Health Service Circular For the Record, Managing records in NHS Trusts and Health Authorities (HSC 1999/053) imposed a duty for Trusts to draw up and begin to implement a records management strategy by 2002
- The Caldicott Review of Patient Identifiable Information (December 1997) raised concerns about the lack of awareness about confidentiality and security, and recommended the establishment of Caldicott 'Guardians' to safeguard the uses made of patient information: these were appointed under HSC 1999/012
- The 1995 Audit Commission report, Setting the Record Straight – A Study of Hospital Medical Records stressed problems arising from low priority given to records, a lack of awareness of the importance of good record keeping, lack of information sharing, lack of co-ordination between paper and electronic records, the tendency of staff to treat records as personal not corporate assets, and a need to balance confidentiality with freeing of information. It recommended that corrective action be taken
- An information strategy for the NHS has been set out in Information for Health, an information strategy for the Modern NHS 1998 – 2005 (HSC 1998/168). Information will increasingly be created, stored and disseminated electronically, as work progresses on the implementation of Electronic Patient Records (EPR) and Electronic Health Records (E.H.R)

- The Modernising Government White Paper (CM 4310, March 1999) sets out the government policy that by 2004 all newly created Public Records will be electronically stored and retrieved
- The Data Protection Act 1998 applies to personal data held in both electronic and paper form, and is designed to strengthen the right to privacy of the individual by ensuring that the processing of personal data (including that done by the NHS for its legitimate purposes) is done in accordance with eight basic principles. The eight principles relate to the fair processing of personal data (processing includes creation, using, storing, handling and disposal or retention), and cover the types of information collected, the uses to which it is put, the accuracy of data, it's timely disposal when no longer required, its security, controls on sharing of information, and processing in accordance with the rights of data subjects. The Data Protection Act significantly extends the requirements for handling personal data in order to achieve compliance.
- The Freedom of Information Act 2000 came into force on 1 January 2005. It applies to all public authorities and gives individuals the right to be told whether information is held, and to have information supplied on request. Information must be supplied if the public interest in disclosure outweighs the public interest in exemption from disclosure. Public authorities have a duty to adopt an approved scheme for the pro-active publication of information, and Health Service Publication Schemes came into effect in October 2003 (The Trust's Publication Scheme is on its website). The Act adds urgency to the need for good records management. The Lord Chancellor's *Code of Practice on the Management of Records under Freedom of Information* sets out the practices which public authorities should follow in relation to creating, keeping, managing and disposing of their records. This states that records management should be recognised as a specific corporate programme with the necessary levels of organisational support, a policy endorsed by top management, and a designated senior member of staff with lead responsibility.
- The Environmental Information Regulations 2004 come into force in early 2005. These strengthen existing regulations and allow public access to environmental information held by public authorities, for example information on air, water, land, wildlife, food, the built environment and environmental health. Topics covered by EIR are potentially quite wide. Access controls and regulations will operate in a similar way to the Freedom of Information Act, and public authorities will need to respond accordingly. For further information see www.defra.gov.uk/environment/pubaccess
- There is a range of other relevant legislation which affects records eg, Human Rights Legislation and specific statutory requirements affecting either particular types of records or particular areas of working
- Information Governance (IG), which is Department of Health policy from 31 October 2003, is the new NHS framework for managing NHS information and records. Information Governance, for the first time,

provides a coherent approach to information, and brings together under one umbrella existing initiatives such as Caldicott and confidentiality, Data Protection, Controls Assurance and Information Quality, and other standards well established in law or recognised best practice, along with newer requirements such as Freedom of Information. The aim of Information Governance is to ensure that information is:

- Held securely and confidentially
- Obtained fairly and efficiently
- Recorded accurately and reliably
- Used effectively and ethically
- Shared appropriately and within the law

A national IG toolkit (on NHSnet) details the standards we are required to meet and provides the mechanism for reporting progress. The toolkit also contains a 'knowledge base' – lots of valuable guidance and information for anyone who works with information in the NHS.

Information Governance is an important component in the measurement of Trust performance. Records management underpins many aspects of Information Governance.

1.5 Managing the 'life cycle' of records

What is a record? The following is a useful definition of records. It shows how wide ranging records can be:

"Records are: recorded information, in any form including data in computer systems … created or received and maintained by an organisation or person … created or received and maintained by an organisation or person … in the transaction of business or the conduct of affairs … and kept as evidence of such activity"

Source : rm3 Partnership, Liverpool University

A record should have the three elements of *content*, *context* and *structure*. The *content* of a record is generally unique; although it can be photocopied or scanned it can never be replaced. The *context* of the record is also unique. The circumstances around the creation of the record cannot be reproduced. Finally the *structure* of a record must be consistent, it must always include the same information type and it must always be in the same format.

In order to understand all the elements contained in any programme of records management, it can be helpful to think of all records as having a *'life cycle'*.

Within the life cycle of a record there will be a number of different stages:

Gestation
Before a record is created, certain decisions will be made about it, for example, the file name, its potential life span and the content of the record.

Creation
This is when most (if not all) of the record is created.
If the record is not used immediately it can remain in this part of the cycle for several weeks. For example, a health record which is created for a future outpatient appointment is issued in anticipation of the appointment but it is not used until the appointment takes place - which can be several months after the record is initially created.
It is important to create quality records (see Part 2 of this Handbook).

Current Life
When a record is used for the first time it enters its current life. A record remains current while it is being used regularly. How regularly a record is used will vary from type to type.
Sometimes a record may enter the semi-current phase (see below) for a time, but then come into frequent use, and become current, again. A record might repeatedly leave and re-enter the current phase over many years.
It is important to use and handle all current records with care, and with regard for security, confidentiality and all proper controls (see Part 2 of this Handbook).

Semi-Current Life
Once a record is used less frequently it enters its semi-active, or semi-current life. Records with a fairly lengthy semi-current life can be transferred to the Trust's Semi-Current Record Centre (see Part 3 of this Handbook) for storage until they either become current again or reach the end of their allotted life span and are disposed of.
A record might move in and out of the semi-current phase for many years until it reaches the end of its retention period.

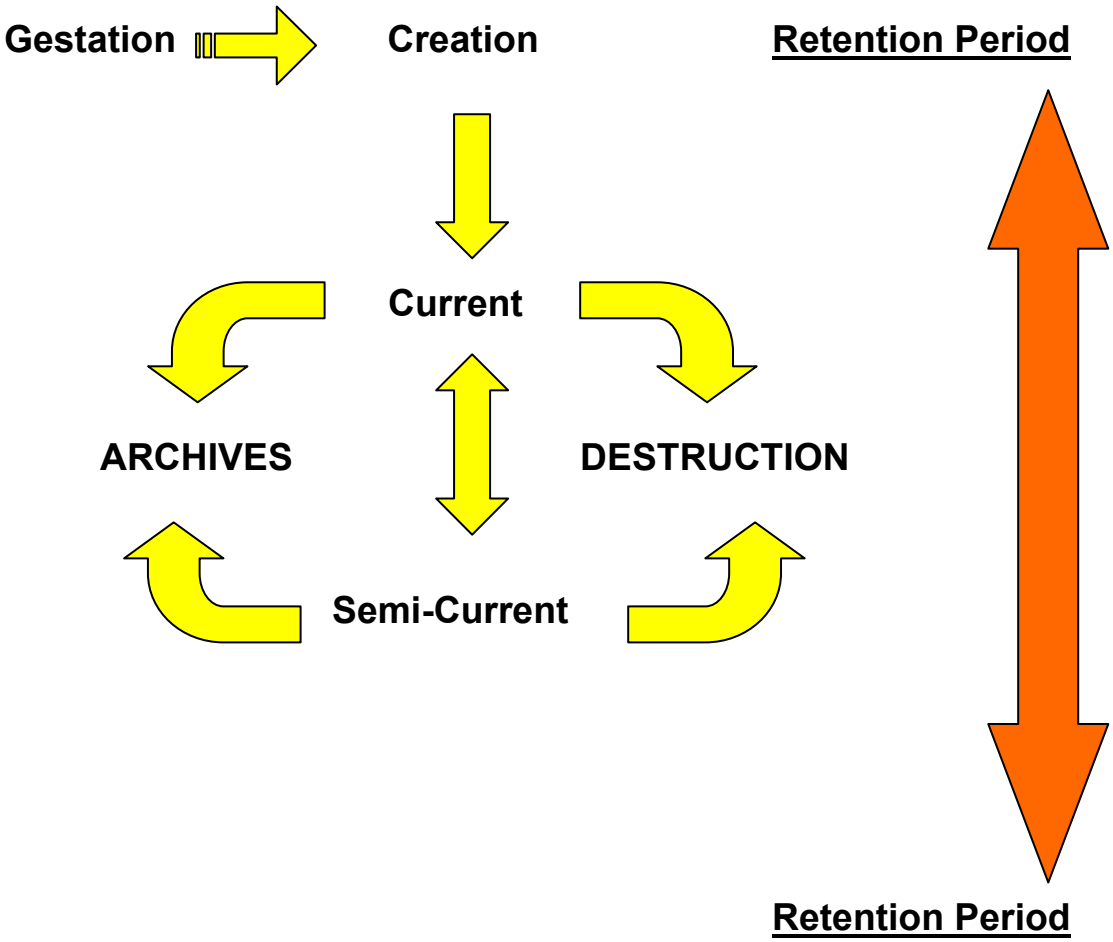
Destruction
Records must only be destroyed once they have reached the end of their life span (their 'retention period'). Destruction should take place in a controlled way – with authorised documentation, a record being kept of what is destroyed, and any confidential waste being destroyed according to Trust Policy.

Retention Periods
The life span of all Trust records – their retention periods – is laid down in the Trust's Retention Schedule (see Part 5 of this Handbook).

Archives
Some records are 'immortal' – ie they need to be kept forever. They form the 'corporate memory' of the Trust's business. Such records

are marked 'for permanent preservation' in the Trust's Retention Schedule. Other records may also be appraised by the Trust Archivist in order to determine any long-term value for research purposes or as historical evidence, and some of these may also be kept permanently.
All records for permanent preservation are transferred to the Trust's Archives (see Part 4 of this Handbook) to be stored in a special environment which ensures long-term preservation. Records stored at the Archives are accessible, under controlled conditions, for the Trust and for researchers.

A Life Cycle Chart



1.6 What do I do now?

The other parts of the Records Management Handbook describe the different elements within the Trust's Record Management Strategy:

Part 2 Creating and Using our Records
Part 3 A Guide to Using the Semi-Current Records Centre
Part 4 A Guide to the Archive Facility
Part 5 The York Hospitals NHS Trust Records Retention and Disposal Schedule for Records

1. Read these Parts of the Handbook and make sure you know about the processes and procedures they describe.
2. Enrol on the Training Courses run by the Trust's Information Team at Groves Chapel (see current Training brochure)
3. Use the Handbook as reference when you want to know what to do with your records.
4. If you have problems or queries, contact our specialist Records Management and Information Governance team at Park House.

Further Information

On the Trust's Intranet:
Information Governance, Data Quality & Security

On the Internet:
Confidentiality Code of Practice
Freedom of Information
Information Commissioner's website
NHSIA IG Leaflet

Contact details:

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Records Management Handbook Part 2
Creating and Using Our Records

2.6 Information Governance in the NHS

The ways in which information is used within the NHS are now subject to *Information Governance* standards.

Information Governance, introduced as Department of Health policy in October 2003, provides, for the first time, a coherent information framework for the NHS – including, within its scope, a variety of previous and new initiatives. It is a web-based knowledge and guidance resource, and an audit and reporting tool, and covers issues of legal compliance, openness, security, quality and accountability. The purpose of Information Governance is to improve the ways in which the NHS creates and uses records - it is designed to ensure that the NHS produces safe, high quality data.

The scope of Information Governance is indicated by the **HORUS** model: ie Information in the NHS should be
Held securely
Obtained fairly
Recorded accurately
Used effectively
Shared ethically.

Information Governance is now mandatory for all health organisations – and it also reminds us that we must all think carefully, in our daily working lives, about how we create and use our records.

2.7 The importance of data quality

An intrinsic part of Information Governance, and of good records management, is ensuring that the quality of data is as high as possible.

All NHS records, of whatever type, should contain accurate information, properly compiled, fit for purpose, and checked appropriately.

For patient data, the issue of quality is particularly important. Concerns in the past about levels of quality have led to the current practice of extensive auditing of NHS patient data. Poor data quality will now jeopardise Trust star ratings.

Lives and services depend on good quality patient data. The NHS has a legal and moral duty to ensure that patient information is complete, accurate and up to date. Mistakes cost the NHS money.

Having to deal with poor data affects staff morale. Planning healthcare services, and measuring their impact, depends, vitally, on accurate information. For full compliance with the Data Protection Act and the Freedom of Information Act the NHS must operate with good quality data.

It is not difficult to spot how poor data can adversely affect the way the Trust's services operate and how its performance is measured. Incorrect addresses on CPD mean the return of large numbers of items sent out to patients – including appointment letters, results and other confidential material. If an admission method is recorded as via A&E rather than from a waiting list this may result in an inaccurate picture of how long a patient has waited for their operation.

It is everyone's responsibility to ensure that data is entered accurately and that routine quality assurance checks are made. Having good data saves our own time, improves the quality of service our patients receive and ensures we comply with legislation.

The Trust has a Data Quality Policy covering patient based information, which lays down accountability within the Trust, the range of initiatives involved in improving data quality, as well as the responsibility of every Trust employee in protecting the integrity and confidentiality of patient information.

2.3 Information Quality Assurance

Information Governance includes standards and processes for Information Quality Assurance (IQA). The process of IQA has replaced Data Accreditation, a previous NHS initiative to measure data quality.

IQA covers exclusively patient information. This includes information on patient demographics, activity data, clinical coding, PAS and clinical systems.

The IQA standards cover the following processes:

- *Communication*
  Internal communications in the Trust should be effective, with all staff being made aware of changes to clinical services, systems and data requirements. External communications should be informative and accurate: for example, the NHS number should be used in all correspondence, and patients should be informed of the Trust's performance.
- *Accountability*
  Data quality is regulated by a clear written policy, under which there is a lead, senior person, as well as clear local responsibility for data quality.

- *Documentation*
  All patient data capture is governed by documented procedures which are current and available to all. All activity should be accounted for and all data items clearly defined.
- *Systems development*
  All systems conform to national standards, and have built-in validation. There is good systems integration and interfaces.
- *Validation and quality assurance*
  There are routine procedures for checking in-patient and outpatient waiting lists, and for checking details about patients. Data collection and recording is monitored to ensure procedures are being followed, and external auditors have approved data capture and reporting methods.
- *Training*
  All staff who have the task of capturing data should have formal training in using IT systems, and in the definitions and functions of data items. They should be trained to operate according to written procedures and guidance, and they should also understand the use and importance of data. Clinical coders should have accredited training.

The task of regular checking and auditing of data quality within the Trust is done by the Data Quality Team. The Team audits CPD information on key access targets, by making sample checks every month. It also validates patient demographic data, and updates and amends data as appropriate. The Team is a useful resource for patient data, and can be contacted when help is needed (see details below).

2.4 Security and confidentiality

The NHS handles a huge quantity of confidential personal information. Everyone working in the NHS has a legal duty to keep personal information safe and confidential.

Back in 1997, the Caldicott Review of Patient Identifiable Information raised concerns about the lack of awareness about confidentiality and security in the NHS, and recommended the establishment of 'Caldicott Guardians' to safeguard the uses made of patient information: every NHS Trust now has a Caldicott Guardian.

In the years since 1997, far more attention has been paid to issues of confidentiality and security of information within the NHS. An NHS Confidentiality Code of Practice was published in 2003.

The Data Protection Act 1998 has also increased the obligations of all people and organisations to hold, process and share personal information with great care, The Act applies to all recorded information about individuals – in the NHS, this means staff as well as patients. The Act gives rights to data subjects to inspect

information held about them and to be told what information will be kept, and for how long, and with whom it will be shared.

York Hospitals NHS Trust, with the Selby and York Primary Care Trust and the North and East Yorkshire and Northern Lincolnshire Strategic Health Authority, has an Information Security Policy, to ensure that information security meets all legal and ethical obligations, and all information is used with due regard for the rights and preferences of individual patients.

The Trust has also produced a leaflet: 'Privacy and Confidentiality of Patient Information' which outlines for patients the process by which they can see information held about them. The leaflet also explains why information is kept, and how it is used and safeguarded.

2.5 Sharing and using information

Concerns about security and confidentiality are balanced by the needs of sharing information, both within, and sometimes also outside, the NHS.

The use and sharing of personal information within the NHS is governed by guidance from the Department of Health, and uses the concept of the 'Safe Haven' ie a set of measures to ensure that confidential personal information is communicated safely and securely.

The Trust has its own Safe Haven Code of Practice, which gives detailed information to all staff who handle personal information. All staff should be familiar with the Code of Practice, which gives practical advice on maintaining privacy of information, whether it be in the form of paper records, computer systems, fax machines, e-mails, or telephone calls. Staff should be vigilant about maintaining security and privacy of information upon Trust premises, and think about how information is handled, to prevent unauthorised or casual access to sensitive data, and how information is shared, which should be done only according to authorised procedures.

Under the Data Protection Act 1998, we must tell data subjects what information we keep and how we use it. We must not keep or share any unnecessary information.

The NHS keeps and uses patient information for a variety of reasons. Primarily, patient data is needed to provide proper care and treatment for individuals, but it might also be used for protecting the public's health generally. Personal information is also kept in order to manage and plan the NHS; to train staff; to pay health care providers; to prepare statistics on performance and activity; to undertake research; and to investigate complaints or legal claims. For some of these uses, information may need to be shared; where the NHS

passes on information, the recipients have the same legal duty to keep it confidential. Information is only passed on where there is genuine need, and where it is possible, personal information should be anonymised.

Maintaining the security and confidentiality of sensitive data, and regulating how we share it, are becoming ever more crucial issues, as new developments mean that information can potentially be disseminated even more widely.

The new NHS National Programme for Information Technology (NPFIT) will involve a huge investment, ensuring consistent standards while exploiting the benefits of IT. Medical records will be held in a national central database, accessed anywhere in the NHS. This new programme will have great implications for the use of technology and maintenance of confidentiality.

The maintenance of security and confidentiality of information also needs to be balanced against the new culture of openness fostered by the Freedom of Information Act 2000, which applies to all public authorities, including the NHS. In practice, the Freedom of Information Act (FOI) will act in tandem with the Data Protection Act (DPA), so the rights of individuals to privacy of information about them will be safeguarded.

FOI gives the public (and this includes NHS staff as individuals) the right to ask whether information is held about any particular topic, and if so, to have access to it. There are exemptions to the types of information which should be released (confidential information about individuals being one), but, as the Information Commissioner (who oversees FOI and DPA) has stated: 'Freedom of Information marks an important step in changing our culture from one based on need to know, to one based on right to know'.

What this means for the Trust is that information about the way we conduct our business, make decisions about allocation of resources, provision of services etc – is now in the public domain. The Trust routinely provides many of its policies, procedures and performance information via a formal Publication Scheme published on the Internet. From 1 January 2005, it must respond to requests for information from members of the general public and the Press.

The challenge to everyone in the Trust who creates records – and this includes agendas and minutes of meetings, and even e-mail correspondence – is that we must be prepared to furnish these in full for public scrutiny. Many requests for information will be routine ones, perhaps ones we have traditionally dealt with. Where requests are more difficult to deal with, they should be passed on to the Information Team.

All NHS staff should be aware in general of the provisions of FOI; and also aware that all requests should be dealt with within 20 days – so if a request needs to be passed onto someone else, this should be done immediately. The Trust has a Freedom of Information Policy, and also a Guidance document for staff, outlining how the Act works and what to do.

The Freedom of Information Act has huge implications, for what we share, what we keep confidential, and how we keep and treat the records themselves. It is more than ever important that we create accurate, objective records, storing them so they are easily accessible, and destroying them when they are no longer needed.

Further Information

On the Trust's Intranet:
Information Governance, Data Quality & Security

On the Internet:
Confidentiality Code of Practice
Freedom of Information
Information Commissioner's website
NHSIA IG Leaflet

Contact details:

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Records Management Handbook Part 3
A Guide to Using the Semi-Current Records Centre

3.1 How the Records Centre works

The Records Centre is based on the Rawcliffe Industrial Estate a short drive from the York Hospital site.

The Records Centre is intended to be used for the storage of records that are no longer needed on a regular basis but have yet to reach the end of their retention period.

Currently there are records from the Health Records Department, Radiology, Occupational Health, Mental Health and Pathology. The Centre will store records of any type, but they must meet certain criteria. First, they must be used infrequently (to keep requests for retrieval to a minimum). Secondly, they must have a retention period (specified and detailed in the Trust's Retention and Disposal Schedule) which is long enough to make storage on-site either difficult or impractical.

If you wish to discuss using the Centre for the first time or if you want to add to your requirements you should contact Dr Kath Webb (tel: 01904 321163 or e-mail kw10@york.ac.uk). Sending the records to the Centre is straightforward, but must be done according to a set procedure, explained below.

You can request records to be retrieved from the Records Centre; they will usually be delivered to you within 2-3 working days, or sooner if possible. Your request can be telephoned or faxed through to the team on 01904 675854. However, you must use the request form RCP/04 (see forms below) to ensure we have all the necessary details.

When records are received into the Records Centre, they are registered on Centre IT systems and allocated an index number.

On an annual basis, a report will be run by Records Centre staff, showing records due to exceed their retention period. Departmental contacts will be notified of records due for destruction, and they will be asked to give authorisation to destroy, using the form RCP/06 below. Once authorisation is received, Records Centre staff will retrieve and destroy the records, and the departmental contact will be informed once destruction has taken place.

3.2 Using the Records Centre

When you use the Records Centre, you follow a set of easy steps. These cover sending records, retrieving records if needed, and

authorising destruction at the end of their retention period. These steps are explained below. In some cases, forms need to be used, and these are also given below.

Step 1. Agreeing storage at the Records Centre for your records

- If you decide you might want to use the facilities of the Records Centre for your semi-current records, you must first contact Kath Webb on 321163 to discuss your requirements. You will need to know: how long the record need to be stored for, whether the records will need to be retrieved, the volume of records to be transferred and whether the whole record or only part of it needs storing.

- If it is agreed that the Records Centre is an appropriate place for storage of your semi-current records, then you will need to complete **Form RC/01 Records Storage Request** (a copy below) and send to Kath Webb for authorisation. This form will be signed and retained by the Records Management Team

- You will not need to go through this process again when you send more records of the same type – but if you want to add some different types of records or in any other way change your requirements then you will need to discuss your needs again.

    - You will need to contact the Records Centre on 675854 if you need to be supplied with a number of archive boxes. You will not receive all the boxes you need at once as this makes transfer difficult, a phased approach is often more effective

    - Once authorisation has been received to transfer records to the Records Centre the records to be transferred must be dealt with in the following way

Step 2. Sending Records to the Records Centre

- Put the notes to be transferred in to the archive box. Please do not overload the boxes as this makes them heavy and unmanageable. Ensure that all the records are facing the front of the box

- Make a list of the records that are stored in the box and put this in the front of the box

- Records will normally be transported to the Records Centre by the Transport Department (unless special arrangements are made for Records Centre staff to collect them directly from the Department).

- Contact Transport Department, on extension 4831, and arrange a specific day, time and location for them to pick up the records. Once you have done this, you should also immediately ring the Records Centre staff on 675854 to alert them of the transport details.

- If Transport are not collecting your records directly from your Department, they should be collected from a designated area. For the York Hospital, this is the goods inward point.

- Records should only be taken to the designated area when the time has come for collection. Records awaiting pick up should not at any time be left unsupervised. **It is your responsibility, as the sending department to ensure the safety of the records while they are in your care. This duty of care extends up to the point of collection.**

- Records must always be accompanied, at transfer, by **duplicate copies** of **Form RC/05 Records Delivery Note.** Each of the two copies should be clearly signed and dated at the point of collection by a member of your staff, and by Transport. This records the handover of the records. Each copy will also be signed and dated by Records Centre staff at the point of delivery. One copy of the form will then be returned to you for your records; the other copy will be kept by the Records Centre.

- If records are collected directly from the department by Records Centre staff, Form RC/05 must still be used, and signed and dated by a member of your staff and by Records Centre staff.

Step 3. Retrieving Records from the Records Centre

- Requests for records can be made either by telephone or fax on 01904 675854

- Requests can be made on an urgent or routine basis. Urgent requests should only be made for records that are needed in the next 24 hours. Routine requests will normally take 2-3 working days depending on the size of request

- Routine requests should be made on **Form RC/02 Records Retrieval Request**. You must supply the record type, reference number, record name and any other information that will help locate the records, for example, box number or date of death

- The records will be retrieved and sent to the Health Records Department in a sealed envelope marked “Private and Confidential” and with the requester’s name and department clearly written on the front

- Please ensure you complete your contact details section on the form in case the Records Centre staff have a query relating to your request

- The records will be retrieved and either sent directly to you via the post room, made available for collection from the Health Records Department or brought directly to you

- If you have requested health records these will be brought to you by the Health Records Courier

PLEASE NOTE: IF YOU TRACK YOUR RECORDS ON ANY TYPE OF SYSTEM, INCLUDING CASE NOTE TRACKING IN CPD, IT IS YOUR RESPONSIBILITY TO UPDATE THIS AS IT IS NOT POSSIBLE TO DO THIS FROM THE RECORDS CENTRE

Step 4. Authorising the Destruction of Records

- On a regular basis you will receive notification that some of the records belonging to your department are due for destruction as they are at the end of the retention period.

- You will receive an authorisation form **RC/03 and a completed Sample Check Form RC/04** (the sample check form indicates that Records Centre staff have retrieved all records due for destruction and checked a 10% sample to ensure accuracy.

- Make necessary checks to ensure the records can legitimately be destroyed. If you are confident that the records can be destroyed this can be noted on the list

- If further investigations are needed the record can be sent to you for review and this should be duly noted on the list

- If a record is reviewed, it must then either be returned to the Records Centre for further storage or destroyed

- If a further review date is to be attached to a record this must discussed with the Trust Archivist. You must state your reasons for retaining the records for longer than the specified retention period.

Contact details:

Kath Webb, Trust Archivist and Records Centre Manager
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York
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Tel: 321163
e-mail: kw10@york.ac.uk

Clive Varley
Semi-Current Records Centre
Unit 1
Rawcliffe Industrial Estate
Manor Lane
York
Tel: 675854

Transport Department
Tel: ext. 4831 (724831 if ringing externally)

Records Centre Forms

Please use these in conjunction with the steps outlined above

Form RC/01 Records Storage Request

Department	
Record Type	
Volume (approximate)	
Record Date(s)	
Current Retention Period	
Method of Destruction	
Transfer Requested by	
Destruction of records to be authorised by (Title)	
Transfer authorised by (Trust Archivist)	

Form RC/02 Request for Retrieval of Records

Department	
Record Type	
Requested by (inc contact details)	
Required by	

Record Number	***Record Name***	***Has the record been retrieved?***	***Comments***

Form RC/03 Notification of Records to be Destroyed, and Destruction Authorisation

I can confirm that the record detailed in the attached form (RC/04) have been authorised for destruction in accordance with the Policy for Records Retention and their Retention and Disposal Schedule of (delete where inapplicable):

- ***York Hospitals Trust***
- ***Selby and York NHS Primary Care Trust***

FOR HEALTH RECORDS:
The records to be destroyed are for patients who have not been treated at the Trust for the past 8 years. The patient is not/has not:

- ***received a blood transfusion in the last 30 years (or the relevant documentation has been removed)***
- ***not younger than 25 years old (or 26 if the young person was 17 at the conclusion of treatment)***
- ***not received a donor organ in the last 11 years***
- ***not undergone a termination of pregnancy in the last 3 years (or the relevant documentation has been removed)***
- ***not received oncology treatment in the last 8 years***
- ***not been involved in a clinical trial in the last 15 years***
- ***not got an ongoing appeal against a refusal to release information under the exemptions of the Freedom of Information Act***

Signed…… Dated…….
Designation……..

RETURN TO RECORDS CENTRE.
A copy will be sent back to you as confirmation, which you should keep safely.
Copies will also be retained by the Trust Archivist and by the Records Centre staff.

Form RC/04 Sample Check form

Department	
Record Type	

These records are due for destruction. They have been retrieved from semi-current storage and are awaiting authorisation to be destroyed. A random sample of these records has been taken to ensure that the destruction complies with York Hospitals Trust Policy for Records Retention and their Retention and Disposal Schedule

Total number of records to be destroyed	
Total number of records checked	***(= %)***

Signed…….

Dated……..

Designation……...

FORM RC/05 *Records Delivery Note*

This form should be completed and signed <u>IN DUPLICATE</u>

One copy will be sent back to the Department by the Records Centre as proof of delivery.
The other copy will be retained by the Records Centre.

Title of Records to be Delivered to Records Centre **(Full list to be inside box)**			**Name of Sending Department**	
COLLECTION DETAILS			**DELIVERY DETAILS**	
Date and Time of Collection	**Sending Department Signature**	**Transport Signature**	**Date and Time of Delivery**	**Records Centre Signature**

Please sign your name clearly

Records Management Handbook Part 4
A Guide to the Archive Facility

4.1 What are Archives?

Archives don't just mean old records – an 'archive' is defined as anything thought worthy of permanent preservation.

4.2 The Trust's Archive Facility

You will note that in the Trust's Record Retention and Disposal Schedule (in Part 5 of this Handbook):

- Some records are immediately designated for **permanent preservation**
- Some records need to be reviewed before being designated for permanent preservation.

The York Hospitals Trust maintains its own Archive Facility. All records designated for permanent preservation must be deposited in the Archives as soon as they are no longer needed for current business.

The Archives are situated at:

The Borthwick Institute for Archives
University of York
Heslington
York
YO10 5DD

The Archivist is Dr Kath Webb, tel: 321163 e-mail: kw10@york.ac.uk

4.3 The Role of the Trust Archives

The Trust Archives holds records for permanent preservation as the Corporate Memory of York Hospitals Trust. It also holds records relating to its predecessor NHS (and pre-NHS) bodies and services, going back to the eighteenth century.

These records are held under special environmental and security conditions which are designed to ensure their long term preservation. They are also made accessible for reference under controlled conditions to staff of the Trust and to others as appropriate.

To arrange transfer of records to the Archives, or to arrange to consult records held at Archives, or for further advice, contact the Archivist.

Further Information

For further details about the Borthwick Institute see www.york.ac.uk/inst/bihr The Borthwick website includes a summary of the archives: click on Summary of Holdings, and then York Health Archives.

Information about the Trust's Archives, and detailed archive catalogues, can be also found on the national Access to Archives (A2A) archive database http://www.a2a.org.uk

There is a published guide to the archives, which includes histories of NHS hospitals and health services:
K.A. Webb, *From County Hospital to NHS Trust. The history and archives of NHS hospitals, services and management in York, 1740-2000* (2 volumes, Borthwick Texts and Calendars 27, University of York, 2002)

Records Management Handbook Part 5
York Hospitals NHS Trust
Retention and Destruction Schedule for Records

5.1 Introduction

This Retention Schedule is based on the national guidelines for the NHS contained in the Health Service Circular 1999/053 *For the Record. Managing records in NHS Trusts and Health Authorities.* This circular is currently being updated.

This Retention Schedules provides guidance on how long to keep records, and what to do with them when they reach the end of their life.

For those records within the Schedule marked 'For Permanent Preservation', or where it is noted that: 'These should be considered for Permanent Preservation: consult with archivist and relevant staff', please contact the archivist:
Dr Kath Webb,
The Borthwick Institute for Archives
University of York
Heslington
York
YO10 5DD
tel: 321163
e-mail: kw10@york.ac.uk

Advice on the Schedule, and on retention periods and related issues, can be sought either from the archivist, or from the Information Team.
Contact:
Kate Ayres
Information Governance Manager (Records Management)
Park House
Bridge Lane,
Wigginton Road,
York
YO31 8ZZ
tel: 6201
e-mail: Kathryn.Ayres@york.NHS.UK

The Retention Schedule is an on-going document – if you have any queries, or if it does not contain details of particular types of records which you would like to receive advice on, or add to the schedule, we would be pleased to hear from you.

5.2 The Retention Schedule

All the records that exist within the Trust have been divided in to the following categories. Click on the links below to view the records in that category.

Activity

Reference	Description
AC/01	Accident & Emergency registers
AC/02	Admission books
AC/03	Admission forms
AC/04	Death registers
AC/05	Diaries
AC/06	Discharge books
AC/07	History of Authority
AC/08	History of Hospital
AC/09	Hospital services
AC/10	Minutes
AC/11	Operating Theatre registers
AC/12	Patient Activity Data
AC/13	Project files >£100,000
AC/14	Project files <£100,000
AC/15	Quality assurance records
AC/16	Ward registers

Reference	Description	Disposal Action	Comments
AC/01	Accident & Emergency registers	Permanent preservation	
AC/02	Admission books	Permanent preservation	
AC/03	Admission forms	Destroy after 6 months	

AC/04	Death registers (registers of deaths kept by the hospital)	Permanent preservation	
AC/05	Diaries	Destroy 1 year after year end	
AC/06	Discharge books (register of those discharged by the hospital)	Permanent preservation	
AC/07	History of Authority of Predecessors, its organisation and procedures	Permanent preservation	
AC/08	History of Hospitals	Permanent preservation	
AC/09	Hospital services	Destroy after 10 years	
	Korner records	See “Patient Activity Data” AC/10	
AC/10	Minutes (reference copies)	Destroy after 1 year	
AC/11	Operating theatres register	Permanent preservation	
AC/12	Patient activity data	Destroy after 3 years	
AC/13	Project files >£100,000	Permanent preservation	
AC/14	Project files <£100,000	Destroy after 6 years	
AC/15	Quality assurance records	Destroy after 12 years	
AC/16	Ward registers	Permanent preservation	

Audit

Reference	Description
AU/01	Audit records
AU/02	Audit reports

Reference	Description	Disposal Action	Comments
AU/01	Audit records – original documents	Destroy after 2 years	Consumer Protection Act 1987
AU/02	Audit reports – including	Destroy after 2	After formal

	management letters, VFM reports and system/final accounts memorandum)	years	clearance by Statutory Auditor

Chief Executive's Office

Reference	Description
CEO/01	Litigation Dossiers
CEO/02	Trust board minutes
CEO/03	Serious Incident files
CEO/04	Other Trust documents
CEO/05	Trust terms
CEO/06	AIRs reports

Reference	Description	Disposal Action	Comments
	Complaints	See "Litigation Dossiers) CEO/01	
CEO/01	Litigation Dossiers (complaints including accident reports) including - Subject files (general) - Subject files (Legal Services – Claims) - Subject files – informal complaints)	Destroy after 10 years	Where legal action has been commenced, keep as advised by legal representatives
CEO/02	Minutes of the NHS Trust or Health Authority, major committees and sub-committees signed	Permanent preservation	
CEO/03	Serious incident files	Permanent preservation	
CEO/04	Trust documents without permanent relevance	Destroy after 6 years	
CEO/05	Trust administered by RHA – terms of	Permanent preservation	
CEO/06	AIRs reports	Destroy after 10 years	

Facilities Management

Reference	Description
FM/01	Accommodation files
FM/02	Asset files
FM/03	Buildings, relating to occupation
FM/04	Buildings, key records

FM/05	Buildings, town and country matters
FM/06	Car parking records
FM/07	Chemical disposal
FM/08	Estate portfolios
FM/09	Food hygiene inspection reports
FM/10	ID badge records
FM/11	Laundry lists and receipts
FM/12	Manuals – policy/procedure
FM/13	Maps
FM/14	Plans – buildings (as built)
FM/15	Plans – buildings (detailed)
FM/16	Plans – engineering
FM/17	Property acquisition dossiers
FM/18	Property disposal dossiers
FM/19	Quotations
FM/20	Rating records
FM/21	Receipts – registered/recorded mail
FM/22	Record of custody and transfer of keys
FM/23	Security alerts
FM/24	Site plans
FM/25	Surveys – building and engineering works
FM/26	Wall washing programme

Reference	Description	Disposal Action	Comments
FM/01	Accommodation files (application forms, occupancy lists, agreements)	For period of occupation	
FM/02	Asset register	Destroy after 11 years	Consumer Protection Act 1987
FM/03	Buildings – papers relating to occupation (but not Health & Safety information)	Destroy after 3 years	After occupation ceases. Construction Design Regulations 1994
FM/04	Buildings and engineering works, inclusive of major projects abandoned or deferred – key records (eg, final accounts, surveys, site plans, bills of quantities)	Permanent preservation	
FM/05	Buildings and engineering works, inclusive of major projects abandoned or deferred – town and country matters and all formal contract documents (eg, executed agreements, conditions	Permanent preservation	The general principle to be followed in regard to these records is that they should be preserved for

	of contract, specifications, “as built” drawings and documents on the appointment and conditions of engagement of private buildings and engineering consultants		the life of the buildings and installations to which they refer
FM/06	Car parking records	Destroy after period of employment ends	
FM/07	Chemical disposal	Destroy after 10 years	
	Drawings	See “Plans” FM/15	
	Engineering works	See “Plans” FM/15	
FM/08	Estate portfolios	See “Site Plans” FM/24	
FM/09	Food hygiene inspection reports	Destroy after 1 year	
FM/10	ID Badge records	Destroy after period of employment ends	
FM/11	Laundry lists and receipts	Destroy after 2 years	From completion of audit
FM/12	Manuals – policy/procedure	Permanent preservation	
FM/13	Maps	Permanent preservation	
FM/14	Plans – buildings (as built)	Permanent preservation	
FM/15	Plans – buildings (detailed)	Lifetime	
FM/16	Plans – engineering	Lifetime	
FM/17	Property acquisition dossiers	Permanent preservation	
FM/18	Property disposal dossiers	Permanent preservation	
FM/19	Quotations	Destroy after 3 years	
FM/20	Rating records	Destroy after 5 years	
FM/21	Receipts for registered and recorded delivery mail	Destroy after 18 months	
FM/22	Record of custody and transfer of keys	Destroy after 18 months	
FM/23	Security alerts	Destroy after 18 months	
	Site files	See “Site Plans” FM/24	
FM/24	Site plans	Permanent	

		Preservation	
FM/25	Surveys – building and engineering works	Permanent Preservation	
FM/26	Wall washing programme	Destroy after end of programme	

Finance

Reference	Description
FI/01	Accounts – annual
FI/02	Accounts – cost
FI/03	Accounts – minor records
FI/04	Bank statements
FI/05	Bills, receipts and cleared cheques
FI/06	Budgets
FI/07	Cash books
FI/08	Cash sheets
FI/09	Creditor payments
FI/10	Debtors Records – cleared
FI/11	Debtors Records – uncleared
FI/12	Demand notes
FI/13	Expense claims
FI/14	Forms – Superannuation
FI/15	Funding data
FI/16	Income & expenditure journals
FI/17	Invoices
FI/18	Ledgers
FI/19	Non-exchequer funds
FI/20	Payroll – full time medical staff
FI/21	Payroll – other staff
FI/22	PAYE records
FI/23	Receipts
FI/24	Superannuation accounts
FI/25	Superannuation registers
FI/26	VAT records
FI/27	Wages/salary records

Reference	Description	Disposal Action	Comments
FI/01	Accounts – annual (final – one set only)	Permanent preservation	
FI/02	Accounts – costs	Destroy after 3 years	
FI/03	Accounts – minor records (pass books; paying in slips; cheque counterfoils; cancelled/discharged cheques	Destroy after 2 years	From completion of audit

	(other than cheques bearing printed receipts); accounts of petty cash expenditure; travelling and subsistence accounts; minor vouchers; duplicate receipts books; income records; laundry lists and receipts		
FI/04	Bank statements	Destroy after 2 years	From completion of audit
FI/05	Bills, receipts and cleared cheques	Destroy after 6 years	
FI/06	Budgets	Destroy after 2 years	From completion of audit
FI/07	Cash books	Destroy after 6 years	The Limitation Act 1980
FI/08	Cash sheets	Destroy after 6 years	The Limitation Act 1980
FI/09	Creditor payments	Destroy after 3 years	
FI/10	Debtors records – cleared	Destroy after 2 years	From completion of audit
FI/11	Debtors records – uncleared	Destroy after 6 years	
FI/12	Demand notes	Destroy after 6 years	
FI/13	Expense claims	Destroy after 2 years	From completion of audit
	Financial records	See under individual headings. However, once the period of retention for audit purposes is complete (2years from completion of audit), documents not required for permanent preservation may be destroyed provided a properly compiled microfilm record is retained for the prescribed period, embodying a suitable certificate by the Treasurer as to it's accuracy and completeness. This does not apply to forms SD55 (ADP) and SD 55J	

FI/14	Forms – Superannuation SD55 (ADP) and SD 55J (copies)	Destroy after 10 years	Originals are sent to the NHS Pensions Agency
FI/15	Funding Data	Destroy after 6 years	
FI/16	Income and expenditure journals	Destroy after 6 years	
FI/17	Invoices	Destroy after 6 years	The Limitation Act 1980
FI/18	Ledgers	Destroy after 6 years	The Limitation Act 1980
FI/19	Non-exchequer fund records	Destroy after 30 years	
FI/20	Payroll – full time medical staff	Destroy after 6 years	For superannuation purposes authorities may wish to retain such records until the subject reaches benefit age
FI/21	Payroll – other staff	Destroy after 6 years	
FI/22	PAYE records	Destroy after 6 years	
FI/23	Receipts	Destroy after 6 years	The Limitation Act 1980
	Salaries	See “Wages” FI/27	
	SD55 (ADP) and SD 55J	See “Forms” FI/14	
FI/24	Superannuation accounts	Destroy after 10 years	
FI/25	Superannuation registers	Destroy after 10 years	
FI/26	VAT Records	Destroy after 6 years	In some instances, a shorter period may be allowed but agreement must be obtained from Customs & Excise – see appendix 2 for details
FI/27	Wages/Salary records	Destroy after 10 years	For superannuation purposes authorities may wish to retain such records until the subject reaches benefit age

Health & Safety

Reference	Description
HS/01	Accident Registers (RIDDOR)
HS/02	Accidental Exposure to radiation
HS/03	COSHH assessment
HS/04	Fire Inspection reports
HS/05	Health & Safety manuals
HS/06	Inspection reports
HS/07	Risk assessment
HS/08	Workplace assessment

Reference	Description	Disposal Action	Comments
HS/01	Accident Forms	See “Litigation Dossiers” CEO/01	
HS/02	Accident registers (RIDDOR)	Destroy after 3 years	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations reg.7; Social Security (Claims and Payments) Regulations, reg.25
HS/03	COSHH assessments	Destroy after 12 year	When new assessment has taken place
HS/04	Fire Inspection reports	Destroy after 1 year	When new assessment has taken place
HS/05	Health & Safety manuals	Permanent preservation	
HS/06	Inspection reports eg, boilers, lifts etc	Lifetime	Normally retain for the lifetime of the installation. However, it is necessary to assess whether obligations incurred during the lifetime may not be invoked until afterwards,

			in which case a judgement must be made. If there is any measurable risk of a liability in respect of installations beyond their operational lives, records of this kind should be retained indefinitely
HS/07	Risk Assessment	Destroy after 1 year	When new assessment has taken place
HS/08	Workplace assessment	Destroy after 1 year	When new assessment has taken place

Health Records

Reference	Description
HR/01	Abortion certificates
HR/02	Blood transfusions records
HR/03	Deceased patient records
HR/04	Hospital patient case records
HR/05	Hospital patient case records – pre 1948
HR/06	Hospital patient case records – children and young people
HR/07	Hospital patient case records – Donor records
HR/08	Hospital patient case records – Maternity
HR/09	Hospital patient case records – Mentally Disordered Persons
HR/10	Hospital patient case records – Oncology
HR/11	Hospital patient case records – Patients involved in clinical trials
HR/12	Microfilmed patient records
HR/13	General patient records
HR/14	Preliminary discharge letters
HR/15	Subject access requests

Reference	Description	Disposal Action	Comments
HR/01	Abortion Certificate A (Form HSA1) and Certificate B	Destroy after 3 years	Abortion Regulations 1991,

	(Emergency Abortion)		Statutory Instrument No.499
HR/02	Blood Transfusion record	Destroy after 30 years	If a patient's hospital case record has a retention date of less than 30 years then the blood transfusion records must be separated from the notes prior to the notes destruction. The blood transfusion records need to be retained for longer.
HR/03	Deceased patient record	Destroy 8 after date of death	
	Health records – personal/patient	See "Hospital patient case records HR/03	
HR/04	Hospital patient case records (individual) NB This retention schedule does not cover GP medical records. Guidance on their retention can be found in HSC 1998/217 and ECL 2/68, both of which remain current at the time of issue of HSC 1999/053 Any reference to "conclusion of treatment" in the following recommended maximum retention periods, should be taken to include all follow-up checks and action in connection with the treatment	The retention periods that are listed below reflect minimum requirements as evidence in legal actions; the minimum retention periods take account of this requirement. It is not necessary to keep every patients. NHS Trusts and Health Authorities should determine, in consultant with their health professionals, which elements should be considered as a permanent part of the record, and which should be transient and discarded as their value ceases. Before any destruction takes place, ensure that (a) there is	

		consultation with relevant health professional body or records committee and actions clearly minuted (b) any other local clinical need is considered; and (c) the value of the record for long term research purposes has been assessed, in consultation with an appropriate place of deposit	
HR/05	Pre 1948 records	Should by now have been transferred for permanent preservation or destroyed. Any pre 1948 records which still exist should be considered for permanent preservation, undergoing an appraisal procedure as described in the box above	
HR/06	Children and young people	Until the patient's 25th birthday, or 26th if the young person was 17 at conclusion of treatment; or 8 years after patient's death if death occurred before the 18th birthday	
HR/07	Donor records	11 years post transplantation	Committee on Microbiological Safety of Blood Tissues for Transplantation (MSBT); guidance issued in 1996
HR/08	Maternity (all obstetric and	Destroy after 25 years	See appendix 1

	midwifery records including those of episodes of maternity care that end in stillbirth or where the child later dies)		for additional guidance on retention and storage of maternity records previously issued with HSG (94) 11
HR/09	Mentally disordered persons (within the meaning of the Mental Health Act 1983)	Destroy after 20 years	Or 8 years after the patient's death if the patient died while receiving treatment
HR/010	Oncology	Destroy 8 years after conclusion of treatment, especially when surgery only is involved	Consideration may wish to be given to BFCO (96) 3 issued by the Royal College of Radiologists which recommends permanent retention on a computer database when patients have been given chemotherapy and radiotherapy
HR/11	Patients involved in clinical trials	15 years after conclusion of treatment	EEC Note for Guidance: Good Clinical Practice for Trials on Medicinal Products on the European Community, section 3.17 (see Pharmacy & Toxicology 1990, 67, 361-372)
	Maternity records	See "Hospital patient case records" HR/06	
	Medical records	See "Hospital patient case records" HR/10	
HR/12	Microfilmed patient records	Indefinitely	
	Midwifery records	See "Hospital patient case records" HR/06	
	Obstetric records	See "Hospital patient case records" HR/06	
	Private patient records admitted	See "Hospital patient	Although

	under section 58 of the National Health Service Act or section 5 of the National Health Service Act of 1946	case records" HR/10	technically exempt from the Public Records Acts, it would be appropriate for authorities to treat such records as if they were not so exempt
HR/13	General (not covered above)	8 years after conclusion of treatment	
HR/14	Preliminary Discharge Letters	Destroy after 2 months	
HR/15	Subject Access requests	Destroy after 5 years	

Human Resources

Reference	Description
HUR/01	CVs for non executive directors (successful)
HUR/02	CVs for non executive directors (unsuccessful)
HUR/03	Establishment records – major
HUR/04	Establishment records – minor
HUR/05	Personal record of hours worked
HUR/06	IDR records
HUR/07	Industrial relations
HUR/08	Job advertisements
HUR/09	Job applications
HUR/10	Job descriptions
HUR/11	Leavers dossiers
HUR/12	Study leave applications
HUR/13	Team brief attendance records
HUR/14	Training records

Reference	Description	Disposal Action	Comments
HUR/01	CVs for non-executive directors (successful)	Destroy after 5 years	Following end of term of office
HUR/02	CVs for non-executive directors (unsuccessful)	Destroy after 2 years	
HUR/03	Establishment records – major (eg, personal files, letters of appointment , contract references and related correspondence)	Destroy after 6 years	Keep 6 years after subject of file leaves service, or until the subject's 70th birthday, whichever is the later. Only the summary need to be kept to age 70; remainder of file

			can be destroyed 6 years after subject leaves service
HUR/04	Establishment records – minor (attendance books, annual leave records, duty rosters, clock cards, timesheets)	Destroy after 2 years	
HUR/05	FWH – Personal Record of hours actually worked	Destroy after 6 months	
HUR/06	IDR records	For period of employment	
HUR/07	Industrial relations (not routine staff matters)	Permanent preservation	
HUR/08	Job advertisements	Destroy after 1 year	
HUR/09	Job applications (following termination of employment)	Destroy after 3 years	
HUR/10	Job descriptions (following termination of employment)	Destroy after 3 years	
HUR/11	Leavers dossiers (provided summary retained)	Destroy after 6 years	
	Letters of appointment	See “Establishment records – major” HUR/03	
	Personnel files	See “Establishment records – major” HUR/03	
	Staff records	See “Establishment records – major” HUR/03	
HUR/12	Study leave application	Destroy after 18 months	
HUR/13	Team brief attendance records	Destroy after 12 months	
	Time sheets	See “Establishment records – minor” HUR/04	
HUR/14	Training records	For period of employment	

Pathology

Reference	Description

PA/01	Pathology records

Reference	Description	Disposal Action	Comments
PA/01	Laboratory records	Permanent preservation	

Purchasing

Reference	Description
PU/01	Advice notes
PU/02	Approved suppliers list
PU/03	Delivery notes
PU/04	Requisitions
PU/05	Stock control reports
PU/06	Stores records – major
PU/07	Stores records – minor
PU/08	Supplies records - minor

Reference	Description	Disposal Action	Comments
PU/01	Advice notes	Destroy after 18 months	
PU/02	Approved supplier list	Destroy after 11 years	Consumer Protection Act 1987
PU/03	Delivery notes	Destroy after 18 months	
PU/04	Requisitions	Destroy after 18 months	
PU/05	Stock control reports	Destroy after 18 months	
PU/06	Stores records – major (stores ledgers etc)	Destroy after 6 years	
PU/07	Stores records – minor (requisitions, issue notes, transfer vouchers, goods received books)	Destroy after 18 months	
PU/08	Supplies records – minor (invitations to tender, inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery, and other supplies)	Destroy after 18 months	

Radiology

Reference	Description
XR/01	X-ray films
XR/02	X-ray reports

Reference	Description	Disposal Action	Comments
XR/01	X-ray films (including all image formats for all imaging modalities)	Destroy 6 years after last X-ray	
XR/02	X-ray reports (including reports for all imaging modalities	Destroy 6 years after last X-ray	To be considered as a permanent part of the patient record – See “Hospital patient case records” HR/10

Pharmacy

Reference	Description
PH/01	Aseptic – CIVAS requests
PH/02	Aseptic – CIVAS worksheets
PH/03	Aseptic – Cytotoxic requests & worksheets
PH/04	Aseptic TPN – Requests & worksheets
PH/05	Dispensary – CD registers
PH/06	Dispensary – CD requisition books
PH/07	Dispensary – Discharge prescription (copies)
PH/08	Dispensary – FP10(HP) returned from PPA
PH/09	Dispensary – Outpatient prescriptions
PH/10	Dispensary – PCPs
PH/11	Dispensary – POD registers
PH/12	Dispensary – Transport dockets
PH/13	Management – EOM budget reports
PH/14	Management – Other finance reports
PH/15	Management printed summary data
PH/16	Management – summary data
PH/17	Medicines Information – Clinical Trial records
PH/18	Medicines Information – Other records
PH/19	Medicines Information – Written Responses

Reference	Description	Disposal Action	Comments
PH/01	Aseptic – CIVAS requests	Destroy after 13 years	
PH/02	Aseptic – CIVAS worksheets	Destroy after 13 years	

PH/03	Aseptic – Cytotoxic requests & worksheet	Destroy after 13 years	
PH/04	Aseptic – TPN Requests & worksheet	Destroy after 13 years	
PH/05	Dispensary – CD registers	Destroy after 2 years	
PH/06	Dispensary – CD Requisition books	Destroy after 2 years	
PH/07	Dispensary – Discharge prescription (copies)	Destroy after 2 weeks	
PH/08	Dispensary – FP10(HP) returned from PPA	Destroy after 2 years	
PH/09	Dispensary – outpatient prescriptions	Destroy after 2 years	
PH/10	Dispensary – PCPs	Destroy after 3 months	
PH/11	Dispensary – POD registers	Destroy after 3 months	
PH/12	Dispensary – Transport dockets	Destroy after 1 week	
PH/13	Management – EOM budget reports	Destroy after 2 years	
PH/14	Management – Other finance reports	Destroy after 10 years	
PH/15	Management – Printed summary sheets	Destroy after 10 years	
PH/16	Management – summary data	Transfer to tape after 4 years	
PH/17	Medicine Information - Clinical trial records	Destroy after 15 years	
PH/18	Medicines Information – Other records	Destroy after 8 years	
PH/19	Medicines Information – Written responses	Destroy after 8 years	