BLT/POL/01606/COR

BARTS AND THE LONDON NHS TRUST

RETENTION AND DISPOSAL OF TRUST RECORDS

TRUST CORE POLICY

REVIEW :	July 2009
APPROVAL/ADOPTED :	Freedom of Information & Corporate Records Group: 10.10.05 Information Governance Steering Group: 30.06.2006 Trust Board: 1996 Trust Executive Group: 04.10.06, 01.11.06 Policies Working Group: 23.01.01 *& review* 21.1.03, 18.10.05, 17.07.2006, 17.10.2006
DISTRIBUTION :	Policy Liaison Officers for distribution to all departments and wards
RELATED POLICIES :	Freedom of Information Policy (BLT/POL/28805/COR) Data Protection Policy (BLT/POL/07903/TOF) Good Health Record Keeping Guidelines (BLT/GUI/273/04/COR) Nursing Documentation Policy (BLT/GUI/08805/NTQ) Code of Practice for Medical Illustration (BLT/POL/01103/MED) Data Quality Policy (BLT/POL/28104/COR) Information Security Policy (BLT/POL/02205/COR) Health Records and Elective Surgery Policy (BLT/POL/00903/MED)
AUTHOR/FURTHER INFORMATION :	Trust Modern Records Manager, 18-4866 / 18-4361; Trust Archivist, 18-4823 Information Governance Manager 18-4691
THIS DOCUMENT REPLACES:	BLT/POL/01605/COR BLT/POL/28204/COR

BLT/POL/01606/COR

INTRODUCTION/PURPOSE OF THE POLICY

1. Records are recorded evidence of activities undertaken by the Trust which are created, received and maintained as evidence and information in pursuance of legal obligations or to facilitate/support the Trust's work.

2. The Trust is dependent upon records to operate efficiently and account for its actions. Records provide a corporate memory and a vital asset which supports the Trust's daily functions, efficient working practices, policy formation, and managerial decision-making. Records protect the rights of patients, staff, members of the public and other organisations which have dealings with the Trust. Poor records management practices may render the Trust open to legal challenge and financial loss from either direct penalties or litigation (expenses as a result of legal settlements), where inadequate records of patient care have been maintained.

3. The Trust has a statutory responsibility under the Public Records Act 1958 to keep accurate and sufficient records of its activities and to ensure that its records are adequately preserved and maintained. In addition, the Lord Chancellor's Code of Practice on records management, issued under Section 46 of the Freedom of Information Act 2000, sets out desirable practice which will enable the Trust to comply with its statutory responsibilities under the Act.

4. This policy follows guidance issued in the Department of Health's *Records Management: NHS Code of Practice,* 30 March 2006[1] and the British standard BS ISO 15489. This policy also contributes towards the fulfilment of Information Governance Toolkit requirements.

5. This policy explains how the Trust will ensure that adequate records are maintained, managed and controlled effectively, commensurate with legal, statutory, operational and information needs. It sets out best practice and common standards and procedures for control of all records from creation to disposal. Guidance will be developed in due course to support the practical implementation of this policy.

[1] This replaces the Health Services Circular HSC 1999/053 *For the Record: Managing records in NHS Trusts and Health Authorities,* 19 March 1999

6. The implementation of this policy will be co-ordinated with policy developments in electronic record-keeping and patient health records as part of the Trust's records management strategy.

APPLICATION

7. This policy applies to all those working in the Trust, in whatever capacity. A failure to follow the requirements of the policy may result in investigation and management action being taken. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement.

THE POLICY

SUMMARY

8. This policy provides guidance on the effective management of records including creation, management, access, retention, disposal, and appraisal for permanent preservation in the Archives, in accordance with current statutory and legislative requirements.

9. It provides a mandate for the performance of records and information management activities. It defines roles and responsibilities including the responsibility of individuals to document their actions and decisions, and to dispose of records. It provides a framework for supporting standards, procedures and guidelines and it indicates the way in which compliance will be monitored. It provides a records retention schedule, in Appendix A, based on minimum recommended retention periods given in national guidelines from the Department of Health (or where applicable, adapted for local circumstances in the Trust).

SCOPE

10. This policy relates to all Trust records. This includes:
    - All administrative records (for example, personnel, estates, financial and accounting records, litigation and complaint handling, project records);
    - All patient health records, including those concerning all specialities and private patients seen on NHS premises (but excluding GP medical records). This includes the central patient

file and any other patient/medical records held across the Trust, and all electronic patient information including texts, images, spreadsheets, databases and all messaging media including email and telephone.

11. This policy applies to records in any format. This includes, but is not limited to:
    - Electronic records, including emails;
    - Paper / manual records;
    - Microfilms / Microfiche;
    - Films, photographs, slides and other images;
    - Audio and video tapes, cassettes, CD-ROM etc.;
    - Material intended for short term or transitory use, including notes and 'spare copies' of documents.

12. The principles for the management and retention of electronic records are the same as for manual records. Emails produced or received in the conduct of business are considered to be part of the corporate record. The technical and procedural requirements for securing the integrity of records held on electronic systems and preserving archival copies will be addressed in future policy development. The Trust will be working towards achieving government targets[2] on electronic records as part of its records management strategy.

CREATION OF RECORDS

13. Each operational unit of the Trust, including third party organisations that are providing services on the Trust's behalf, must have in place adequate systems for documenting their activities (where appropriate), particularly where the activities/services are in relation to the provision of patient care. Records should be complete and accurate enough to allow employees and their successors to:

    - Facilitate an audit or examination of the activity or functions performed;
    - Protect the legal rights or other rights of the Trust, its clients and any other person affected by its actions;
    - Provide authenticity of the records so that the evidence derived from the records is credible and authoritative.

[2] *Modernising Government,* March 1999

14. All records should be legible and accurate. Where personal data are concerned, it is a requirement of the Data Protection Act 1998 that "personal data shall be accurate and where appropriate, up to date". This is covered in more detail in the Trust's Data Protection Policy (BLT/POL/07903/TOF).

15. In order to ensure that records are authentic and accurate, they should be created as soon as possible during or after the activity to which they relate. Records created long afterwards are more open to challenge in the event of a legal dispute.

16. Records should be stored in a relevant filing system as soon as possible after creation (for electronic records this may be a shared drive or other approved Trust software). Records should be filed in such a way that it is clear what the record contains and the organisational context in which it was created. The record should be easily retrievable and filed in such a way that the information can be promptly destroyed in accordance with the Retention Schedule (see Appendix A) when it is no longer needed. Referencing, titling and indexing systems should be logical and easily understandable.

17. Where records have a direct relationship to other collections of records in the Trust, this should be explicitly documented to enable a full record to be retrieved. This is particularly important where patient information is held separately from the main patient case file.

18. The Modern Records Manager maintains a central register of the different record types held across the Trust. If any new series of records are created, for example because a new service is set up, then the Modern Records Manager should be informed so that the register can be updated.

ISSUES SPECIFIC TO HEALTH RECORDS

19. Health records are essential to the provision and delivery of high quality, evidence based health care to patients, to the efficient running of the Trust and the management of complaints and litigation. The information contained in health records is only usable if it is correctly recorded in the first place, is regularly updated and is easily accessible when needed. With an effective system of health records management in place, it is possible to:
    - support continuity of patient care;
    - support day to day business, which underpins delivery of care;

- support evidence based practice;
- support the principles of clinical governance;
- support sound clinical, administrative and managerial decision making;
- meet legal requirements and standards in handling and access to patient information;
- support clinical audits;
- support improvements in clinical effectiveness through research
- support archival function by taking account of the historical importance of material and the future research needs; and
- provide information whenever and wherever there is a justified need and in whatever media it is required.

20. There must be one main case record for each patient. Therapies and other specialisms that hold separate records must ensure that the main record holds a summary of the separate record or that the separate records are filed into the main record at the end the period of treatment, e.g. for a maternity episode – after the birth of the child. A copy of the A & E casualty card must be filed to the main patient file for patients who are admitted.

21. Full and accurate records must be kept which:
    - provide current, comprehensive and concise information concerning the condition and care of the patient and associated observations;
    - provide reliable evidence of care provided, intervention by professional practitioners and patient responses;
    - include a record of any factors (physical, psychological or social) that may affect the patient's treatment;
    - record the chronology of events and the reasons for any decisions made;
    - support standard setting, quality assessment and audit; and
    - provide a baseline record against which improvement or deterioration may be judged.

22. Information must meet the standards set in the Trust Good Health Record Keeping Guide and:
    - be recorded in a timely manner;
    - identify factors, which jeopardise standards or place the patient at risk;
    - provide evidence of the need, in specific cases, for practitioners with special knowledge and skills;

- aid patient involvement in their own care;
- provide evidence to answer possible complaints that may be made;
- be written, wherever possible, in terms that the patient will be able to understand; and
- use the NHS number for both internal and external correspondence.

23. Health records should provide a care pathway and a communication channel inter-departmentally and inter-professionally through the accurate and prompt documentation of each episode of care received by the patient. Elective surgery and invasive procedures should not be performed unless the health record is available except in accordance with the Trust policy on Health records and Elective Surgery.

24. Information must be arranged in a logical structure and sequence which facilitates subsequent use and reference. Filing in health records will be in chronological order within each section and will include all clinical and nursing information in accordance with the Integrated Health care notes procedure developed by the Nursing Quality team.

25. All patient records are currently registered using a 6 million patient case-note number through the Patient Administration System.

MANAGEMENT AND STORAGE OF RECORDS

26. Storage accommodation for manual records should be clean, tidy, secure, and comply with Health and Safety regulations. The storage should prevent unauthorised access and damage from fire, flood, or theft. Unless necessary for reasons of patient care, Trust records must not be stored in areas which are open to the public and should never be left in corridors or generally open public areas.

27. Electronic records should be stored on Trust systems or shared drives, which are regularly backed up and stored securely. Trust records must not be stored on local drives (e.g. C: drive or desktop) or on home computers. Home computers may be used for legitimate home working but records must always be returned to the Trust for safekeeping once the work has been completed. Personal drives (e.g. H: drive) on the file server should only be used for the storage of personal information, temporary documents or documents in draft.

ICT is responsible for ensuring that all electronic systems are compliant with International Information Security standards.

28. Duplication should generally be avoided unless absolutely necessary. There is usually a need to maintain only one master set of records. It should be clear from the outset who is responsible for maintaining the master set so that unnecessary duplication does not occur. Duplicates can be clearly marked as copies to avoid confusion.

29. Records containing confidential (sensitive personal) information must be secured against unauthorised access. Confidential records in manual format must be held securely in locked secure cabinets or stores. Confidential electronic records should be stored within an appropriate system which allows for appropriate security provisions to be set.[3]

30. Records should be stored in a robust format which remains readable for as long as the records are required by the retention schedule in Appendix A. Departments are responsible for ensuring that records in their care are adequately preserved and are kept in good condition. Advice can be obtained from the Modern Records Manager or the Trust Archivists.

31. If any records are converted to a new format (e.g. microfilm, scanning, CD-ROM), consideration must be given to whether the new format will allow the records to be preserved for as long as they are needed, and remain accessible for the full period they are retained.

32. Records which are vital to the continued functioning of the Trust should be covered by a business recovery plan / contingency plan.

33. Records which have a short-term retention (i.e. 3 years or less) may be stored locally, but it is recommended that records requiring storage for longer than 3 years are transferred to central storage areas. Advice on extended records storage, including copying to other formats, can be obtained from the Trust's Modern Records Manager.

[3] The Information Security Policy (BLT/POL/02203/COR) provides further guidance.

34. Records should be closed as soon as they have ceased to be of active use other than for reference purposes. As a general guideline, administrative files should be closed after a maximum of five years, and if action continues, a further file should be created. The fact that a record or file has been closed should be clearly indicated on the file and on any relevant lists or indexes.

35. Individual master versions of finalised documents should be saved in a format which ensures that they can not be edited.

ACCESS TO RECORDS

36. Records and information within them should be efficiently retrievable by those with a legitimate right of access, for as long as the records are held by the Trust.

37. Access to information in records is governed by the Freedom of Information Act and the Data Protection Act. These are discussed in more detail in other Trust policies. In order for records to be accessible under these Acts, it is important that records are:
    - Created promptly;
    - Named, referenced, or indexed appropriately;
    - Filed in a suitable location;
    - Protected from unauthorised alteration or deleted;
    - Maintained over time.

38. The Public Records Act states that the Trust Archives must provide facilities for the inspection of records by the public, which are comparable to the facilities at The National Archives. The facilities provided by the Trust Archives are periodically inspected by The National Archives against national standards and guidelines. The Trust Modern Records Centre also provides facilities for Trust records held in the Centre to be viewed, where appropriate.

39. Confidentiality of patient or other personal data must be maintained at all times; handling and exchange of patient information must comply with the Data Protection Act 1998 and the Access to Health Records Act 1990 Access to patient information is permitted only to those with a professional or contractual duty of confidentiality and in accordance with Trust core policies on Data Protection, Information Security**,** and Code of Confidentiality.

40. Central medical libraries provide 24 hour cover for access to current health records. Electronic tracking systems control the movement of all patient records to enable:
    - Records to be located and retrieved when required;
    - prevent loss of records;
    - maintain an auditable trail of record transactions.

RETENTION

41. The schedule in *Appendix A* is based on guidance issued in the Department of Health's *Records Management: NHS Code of Practice,* 30 March 2006[4], adapted for local circumstances of the Trust.

42. Variations to the schedule may be issued from time to time to take account of new legislative or business requirements. Where this occurs, the policy will be updated and new guidance issued to relevant Trust Departments, where necessary.

43. Retention decisions must take into account statutory requirements for public records, local business needs and appraisal for archival value. It is important that retention periods, once agreed, are documented and applied consistently for the same types of records across the Trust.

44. Any proposed changes to the retention periods set out in Appendix A must be fully considered by all those affected. A proposal containing the full justification for the proposed change should be submitted to the Information Governance Steering Group for consideration on the template provided in Appendix B.

DISPOSAL

45. Disposal of records at the end of their retention period can involve destruction or, for records to be permanently preserved, transfer to the Trust Archives.

46. Under the Public Records Act, NHS records over 30 years old which have been selected for permanent preservation and which are not in current use by the creating Department must be transferred to a

[4] This replaces the Health Services Circular HSC 1999/053 *For the Record: Managing records in NHS Trusts and Health Authorities,* 19 March 1999

recognised place of deposit. Within the Trust and in respect of Trust records, the approved places of deposit are the Trust Archive service based at Prescot St and St Bartholomew's Hospital.

47. Those responsible for storing records must ensure that disposal takes place in accordance with the retention schedule, and that disposals occur promptly and consistently. In most cases an annual disposal will take place at the beginning of each year (or financial year for financial records), but in some cases it may be appropriate to do so monthly basis. Regular disposal of records (including electronic records) in accordance with the retention schedule is vital to promote the efficient use of space and resources within the Trust and ensure that information is not retained for longer than is necessary for the purpose for which it was recorded.

48. Disposal of Trust records to any other organisation must be undertaken in accordance with the Public Records Act 1958. Records held on the Trust's behalf by external organisations must be managed in accordance with this Policy. Advice and guidance should be sought from the Modern Records Manager.

DESTRUCTION OF RECORDS

49. Destruction of records should only take place in accordance with the retention schedule in Appendix A. The destruction of any records must be clearly documented. Where records have been passed to the Trust Records Centre, the Modern Records Manager will maintain central destruction registers of destructions made. Lists or indexes for records destroyed locally should be kept indefinitely by the responsible department. A note should be made with the lists of the date the records were destroyed and a record kept of any approvals which were necessary for their destruction.

50. Where no separate lists or indexes exist (e.g. large series of routine records which are filed numerically or alphabetically), the date of destruction, types of records and covering dates of destroyed records should be recorded.

51. Records must not be destroyed in contravention of the Trust retention schedule without prior consultation with and approval from the Information Governance Steering Group. The full justification for any proposed destruction contrary to this Policy should be

submitted to the Information Governance Steering Group for consideration on the template provided in Appendix B.

52. For records not already in the public domain (i.e. published or already accessible records), it is vital that confidentiality is safeguarded at every stage including destruction.

53. The recommended method of destruction for manual records is by placing in confidential waste bags or bins, or by shredding. If this service is provided by a contractor, it is the responsibility of the Trust to satisfy itself that, at all stages of destruction, including transport to destruction sites, adequate safeguards are provided against accidental loss or disclosure. Risk Management department can advise on procedures.

54. Electronic records should be fully erased from Trust servers and systems. Advice and guidance can be obtained from the ICT Service Desk.

55. It is a criminal offence under the Freedom of Information Act to destroy or alter information that has been requested in an attempt to avoid disclosure.

56. If a record due for destruction is known to be the subject of a request for information, destruction should be delayed. If it would take an excessive amount of time and effort to extract the record from those due for destruction because the destruction process has already partially begun, then this may be taken into account when calculating whether the enquiry will extend beyond the fees limit. Once the information request is completed, the record should be retained until the complaint and appeal provisions of the Freedom of Information Act have been exhausted.

COMPLIANCE / MONITORING

57. Compliance with this policy will be monitored by the Modern Records Manager, as part of the Trust Records Management Strategy, under the wider aegis of the Trust Information Governance programme.

ROLES AND RESPONSIBILITIES

58. Chief Executives and senior managers of all NHS bodies are personally accountable for the quality of records management within their organisations and have a duty to make arrangements for the safe-keeping of the records of their organisation.

59. The Information Governance Manager is responsible for co-ordinating all Information Governance work across the Trust. See the Information Governance Policy (BLT/POL/29605/COR) for further information.

60. Members of staff and third party organisations providing services to the Trust, are responsible for documenting their actions and decisions and for maintaining the records they use. Any records created by or on behalf of the NHS are Public Records as defined by law.

61. Line-managers and supervisors must ensure that their staff are adequately trained and apply the appropriate guidelines. It is essential that all Trust staff who handle patient health records are made aware of the key principles of the Trust records management policies at induction, notably in respect of confidentiality and Data Protection legislation.

62. The Trust Modern Records Manager is responsible for co-ordinating and advising on the implementation of this policy across the Trust. This includes the development of practical guidance on various aspects of this policy, procedures, local records retention schedules, maintenance of accurate inventories of record-holdings and registers of destructions. The Modern Records Manager manages the Trust Records Centre based at Prescot Street.

63. The Trust Health Records Department provides a Trust wide service, primarily responsible for the cohesive, efficient and effective storage and retrieval of patient health records. Guidance on health records (Good Health Record Keeping Guidelines) has been issued. The Health Records Improvement Board oversees the implementation and review of standards for management of health records.

64. The Trust Archivists are responsible for selection of records for permanent preservation and the maintenance of the archives of the Trust.

Catherine Redfern, Trust Modern Records Manager July 2006

References

- Public Records Act 1958
- Freedom of Information Act 2000
- Data Protection Act 1998
- Information Governance Toolkit
- BS ISO 15489 Information and documentation – Records Management (2001)
- Lord Chancellor's Code of Practice on the Management of Records Under Section 46 of the Freedom of Information Act 2000 (2002)
- Department of Health: *Records Management: NHS Code of Practice,* 30 March 2006
- The National Archives: Complying with the Records Management Code: Evaluation Workbook and Methodology, consultation draft (June 2005)

APPENDIX A
Retention and Disposal Schedule

This schedule may be subject to change as guidance is published by the Department of Health or other professional bodies. Always consult the master version.

Introduction

This schedule specifies retention periods based on the minimum retention periods set out in the Department of Health's *Records Management: NHS Code of Practice,* 30 March 2006. It incorporates adjustments to the recommended periods to accommodate legal and business requirements of the Trust. Proposals to change any of the retention periods should be submitted to the Information Governance Steering Group using the template in Appendix B.

Contents

How to use this retention and disposal schedule

- **Type of record** – Type of record to be retained
- **Notes** - Statutory requirements / legislative authority or explanatory notes
- **Retain (Years)** - Retention periods should be calculated from the date of the last document in the file/document set, unless otherwise specified. For most records the retention period should be calculated from the end of the calendar year (e.g. a file with a last document dated August 2000 and a retention of 6 years will retained until January 2007, not January 2006). For financial papers the retention period should be calculated from the end of the accounting year, i.e. 31 March. (e.g. invoices dated March 2000 with a retention of 6 years will destroyed in April 2006 but invoices dated April 2000 would not be destroyed until April 2007).
- **Final Action** – What to do with the record when the retention period is complete. If in doubt contact the Trust Records Centre, details below.

Contacts

- **Trust Records Centre, 9 Prescot St** – 18-4866 / 18-4361 - For storage of corporate / administrative records during their retention period.
- **Health Records Department** – 14-3498 / 14-7149 / 15-7012 - For advice on health records.
- **Trust Archives** – Storage of records retained permanently by the Trust due to their historical / research value. Telephone: Royal London Hospital Archives (14-7608 / 18-4823); St. Bartholomew's Hospital Archives (15-8152).

Barts and the London NHS Trust
RETENTION AND DISPOSAL SCHEDULE

ADMINISTRATION / MANAGEMENT			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Access control data	See Keys		
Accident forms	See Incident reports		
Accident register (RIDDOR)	See Incident reports [Reporting of injuries, diseases and dangerous occurrences regulations RIDDOR, reg. 7; Social Security Regulations, reg. 25]		
Advance letters (e.g. DH guidance)		6	Destroy
Agenda files	See Meeting Papers		
Annual Reports		Permanent	Transfer to Archives
Business plans, including local delivery plans		20	Offer to Archives
Chaplaincy records		2	Offer to Archives
Close Circuit TV (CCTV) images	Information Commissioner: CCTV Code of Practice	No longer than 31 days	Destroy
Commissioning decisions: appeal documentation and decision documentation	Retention calculated from date of appeal or decision	6	Offer to Archives
Complaints – correspondence, investigation and outcome		10	Destroy
Complaints – annual returns to Department of Health	See Statistics		
Day files (chronological file of correspondence)	n.b. master version of correspondence should be filed onto the relevant subject record	0.5	Destroy
Diaries (office)		1	Destroy
Events (special events records, open days, etc)		5	Offer to Archives

ADMINISTRATION / MANAGEMENT			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Exposure monitoring records (not staff specific)	For individual staff records See Occupational Health Control of Substances Hazardous to Health Regulations 2002 (reg. 10(5))	5	Destroy
Family Health Services Appeals Authority tribunal and case files: - Case files - Decision records		 10 Until 80th birthday	 Offer to Archives
Forms AP1, 2, and 4	See Surgical Appliances		
History of Trust/Hospitals, their organisation and procedures		Permanent	Transfer to Archives
Incident reports: - Top (white) copies - Local registers / incident report books (blue/yellow copies)	 See also: Serious Untoward Incident files	 8 2	 Destroy Destroy
Keys - records of custody and transfer of keys, including access control system data		2	Destroy
Korner records	See Statistics		
Laundry lists / receipts	See Financial records – Accounts - Minor		
Lists / indexes of records destroyed in accordance with this schedule / records destruction log		Permanent	Transfer to Records Manager
Litigation records		10	Destroy
Manuals – operating	See also Buildings / Estates section - Inspection reports	Lifetime of equipment	Offer to Archives
Manuals – policy and procedure	See Policies and procedures		
Medical device alerts	www.mhra.gov.uk	Retain until updated or withdrawn (check MHRA website)	Destroy

ADMINISTRATION / MANAGEMENT			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Meeting Papers / Minutes / Agendas – board meetings, major committees, sub-committees, predecessors		5	Permanent - Transfer to Archives
Meeting Papers / Minutes / Agendas – departmental meetings, minor committees		10	Offer to Archives
Meeting Papers / Minutes / Agendas - reference / duplicate copies		Destroy when meeting complete	Destroy
Newsletters, publications, magazines		Permanent	Transfer to Archives
Patient Activity data	See Statistics		
Patient information leaflets		Permanent	Transfer to Archives
Patient property books / registers (property handed in for safekeeping)	See Patient Property Policy for further guidance	6	Destroy
Photographs (non clinical)		5	Offer to Archives
Policies and procedure manuals		10	Permanent – Transfer to Archives
Press Cuttings (master set)	Mint set transferred direct to Archives	1	Offer to Archives
Quality Assurance Records (e.g. Healthcare Commission, Audit Commission, King's Fund Organisational Audit, Investors in People)	For quality assurance in Pharmacy See Pharmacy section	12	Offer to Archives
Receipts – registered / Recorded delivery mail		2	Destroy
Reports (major)		10	Offer to Archives

ADMINISTRATION / MANAGEMENT			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Requests for Information: - Subject Access Requests (Data Protection Act) - Freedom of Information requests - Assembly / Parliamentary questions, MP enquiries		 3 3 (full disclosure) 10 (not disclosed) 10	 Destroy Destroy Destroy
Research and Development general administration (overall management, funding, organisation, strategy etc)	For individual research project / trial records See Patient / Health section – Clinical Research	15	Offer to Archives
Risk assessment forms		10	Destroy
Security case files	Counter Fraud and Security Management Service Guidelines	6	Destroy
Serious Untoward Incident files	See also Incident reports Trust Executive Group 01/11/06	30	Offer to Archives
Software - licences and documentation for computer programmes written in-house		Lifetime of software	Destroy
Staff administration / line management	See Human Resources / Personnel section		
Statistics (including Korner returns, ERIC returns, contract minimum data set, security statistics, statistical returns to DH, patient activity)		3	Destroy
Subject files (e.g. Director's subject files)		5	Review & retain if still required. If not, offer to Archives
Surgical Appliances – Forms AP1, 2, and 4	Retention calculated from completion of audit	2	Destroy

ADMINISTRATION / MANAGEMENT			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Transport (staff car pool documentation	If litigation ensues, may be required for longer	3	Destroy

BUILDINGS / ESTATES			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Asbestos surveys and reports	Control of Asbestos at Work Regulations 1987	40	Review, retain for longer if necessary, Offer to Archives.
Buildings and engineering works (including major projects abandoned/deferred) 1. Key records (e.g. Final accounts, surveys, site plans, building plans, bills of quantities) 2. Planning matters and formal contract documents (e.g. Executed agreements, conditions of contract, specifications, 'as built' record drawings, documents re appointment and conditions of private buildings and private / engineering consultants)	See also: Financial section – Private Finance Initiative	 30 Lifetime of building or 30 yrs	 Permanent - Transfer to Archives Offer to Archives
Buildings – papers relating to occupation (but not Health & Safety information)	Retention to be calculated from date occupation ceases. Construction Design Management Regulations, 1994	3	Destroy
Deeds of Title	See Leases		
Drawings – plans and buildings /elevations (architect signed, not copies)		Lifetime of building	Offer to Archives
Engineering works – plans and building records	Retention to take account of legal liability. See also Buildings; Inspection reports	Lifetime of installation or building	Offer to Archives
Equipment – records of non fixed equipment, including specification, test records, maintenance records and logs	[Consumer Protection Act 1987]	11	Destroy

BUILDINGS / ESTATES			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Inspection reports – e.g. Boilers, lifts etc.	If measurable risk of a liability in respect of installations beyond their operational lives, retain for longer if necessary.	Lifetime of installation	Offer to Archives
Inventories of furniture, medical and surgical equipment not held on store charge and with a minimum life of 5 years		30	Offer to Archives
Inventories (not in current use) of items having a life of less than 5 years		1.5	Destroy
Inventories of plant and permanent or fixed equipment	Part of the lease information – See Leases		
Land surveys/registers		10	Permanent-Archives
Leases / Deeds of Title	Limitation Act 1980	20	Permanent - Archives
Maps		10	Permanent - Archives
Mortgage documents		30	Offer to Archives
Photographs of buildings		Lifetime of building	Offer to Archives
Plans – Building (Architectural - signed)		10	Permanent - Archives
Plans – Building (Detailed)		Lifetime	Offer to Archives
Plans – Engineering		Lifetime	Offer to Archives
Property / Acquisitions / Disposal dossiers		20	Permanent - Archives
Radioactive waste	Radioactive Substances Act 1993	30	Offer to Archives
Site Files		Lifetime of site	Offer to Archives
Surveys		Lifetime of building or installation	Offer to Archives

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Accounts – annual (Final – one set only)		Permanent	Transfer to Archives
Accounts – cost		3	Destroy
Accounts – minor records: pass books; paying-in slips; cheque counterfoils; cancelled/discharged cheques without receipts; accounts of petty cash expenditure; travelling and subsistence accounts, minor vouchers; duplicate receipt books; income records; laundry lists/receipts	Retention to be calculated from completion of the audit. (See Receipts for cheques bearing printed receipts)	2	Destroy
Accounts – working papers		3	Destroy
Advice notes (payment)		1.5	Destroy
Agreements	See Contracts		
Appeals papers – minor accounting records etc Appeals papers – major records	See also Accounts – minor	3 8	Destroy Offer to Archives
Approval files (Contracts)	See Contracts - financial		
Approved Suppliers Lists	See Contracts - financial		
Audit reports – internal (e.g. ward cleanliness reports)	Retention calculated from completion of the audit.	2	Destroy
Audit reports - external (inc.Value For Money reports, management letters system/final accounts memo)	Retention calculated from completion of the audit.	6	Destroy
Bank Statements	Retention calculated from completion of the audit.	2	Destroy
Banks Automated Clearing System (BACS) records		6	Destroy

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Benefactions: - General records relating to benefactions - Where benefaction Endowment Trust Fund / capital interest remains permanent / legacies		 8 Permanent	 Offer to Archives Transfer to Archives
Bills, receipts and cleared cheques		6	
Budgets (including working papers, reports, virements and journals)	Retention calculated from completion of the audit.	2	Destroy
Capital charges data	Retention calculated from completion of the audit.	2	
Capital paid invoices	See Invoices		
Cash books	[The Limitation Act, 1980]	6	Destroy
Cash sheets	[The Limitation Act, 1980]	6	Destroy
Charitable Foundation records	Contact Modern Records Manager or Archivist for advice.		
Contracts – financial: - Approval files - Approved suppliers list	 Consumer Protection Act 1987	 15 11	 Destroy Destroy
Contracts – non sealed (property & other)	Retention calculated from termination of the contract. [The Limitation Act, 1980]	6	Destroy
Contracts – sealed (and associated records)	Retention calculated from termination of the contract. [The Limitation Act, 1980]	15	Offer to Archives

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Contractual arrangements with hospitals or other bodies outside the NHS, including papers relating to financial settlements made under the contract (e.g. waiting list initiative)		6	Offer to Archives
Cost accounts	See Accounts		
Creditor payments		3	Destroy
Debtors' records – cleared	Retention calculated from completion of the audit.	2	Destroy
Debtors' records – uncleared		6	Destroy
Demand notes		6	Destroy
Delivery notes		2	Destroy
Estimates (including supporting calculations and statistics)	Retention calculated from completion of the audit.	3	Destroy
Excess fares		2	Destroy
Expense claims, including travel & subsistence claims and authorisations	Retention calculated from completion of the audit.	5	Destroy
Forms SD 55 (ADP) and SD 55J	See Superannuation		
Fraud case files / investigations		6	Destroy
Fraud national proactive exercises		3	Destroy
Funding data		6	Destroy
Fundraising records		6	Offer to Archives
General Medical Services payments		6	Destroy
Income and expenditure journals		6	Offer to Archives
Invoices	[The Limitation Act, 1980]	6	Destroy
Laundry lists and receipts	See Accounts - minor		
Ledgers (including cash books, ledgers, income and expenditure journals, nominal rolls, non-exchequer funds records (patient monies)	[The Limitation Act, 1980]	6	Offer to Archives
Legacy records	See Benefactions		

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Maintenance contracts – routine	See Contracts		
Nominal Rolls		6	Offer to Archives
Non-Exchequer funds records	See also Appeals and Benefactions Exempt from Public Records Act – but treat as Public Records	30	Offer to Archives
Orders	See Stores records - minor		
Patents / Trademarks / Intellectual property: - applications for patents /original patent documents - licensing / assignment of patents to third parties, infringements of patents	 Limitation Act 1980	 Lifetime of patent 6 from termination of license / action	 Offer to Archives Destroy
Pay Roll / PAYE – full-time medical staff and other staff Microfilm/fiche copies	North East London Pay Consortium Retention calculated from termination of employment See also Superannuation	6 Permanent	Destroy Transfer to Archives
Payments		6	Destroy
Patient property books	See Administration / Management section		
Positive predictive value performance indicators		3	Destroy
Private Finance Initiative (PFI) – major records e.g. change control process records, specifications, full business case, contracts.	See also: Buildings / Estates: planning matters	Lifetime of PFI	Offer to Archives
Products – Liability	[Consumer Protection Act, 1987]	11	Destroy

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Project Files – Low Risk (less than £100,000) – High Risk (over £100,000) including abandoned or deferred projects	Retention calculated from termination of the project	6 6	Destroy Offer to Archives
Receipts	[The Limitation Act, 1980]	6	Destroy
Requisitions	See Stores records - minor		
SD 55 (ADP) and SD 55J	See Superannuation		
Service Agreements	See Contracts		
Specifications	[The Limitation Act, 1980]	6	Destroy
Superannuation records / registers (including accounts and forms, SD 55 (ADP) and SD 55J)	Held by North East London Pay Consortium Retention calculated from termination of employment Originals sent to NHS Pensions Agency [Records are microfilmed before destruction]	10	Destroy
Stock Control Reports		1.5	Destroy
Stores Records – major (stores ledgers etc,)		6	Destroy
Stores records – minor (requisitions, issue notes, transfer vouchers, goods received, books, orders etc.)		1.5	Destroy
Supplies records – minor, e.g. routine papers relating to catering, equipment, stationery, order requisitions etc.		1.5	Destroy
Tax forms		6	
Tenders (successful)		6	
Tenders (unsuccessful)	[The Limitation Act, 1980]	6	Destroy

FINANCIAL / PURCHASING / CONTRACTS n.b. retention of financial records to be calculated from end of financial year, not calendar year (unless otherwise stated)			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
VAT Records VAT Records – Lennartz VAT Scheme		6 30 then review to see if required for longer	Destroy Destroy
Wages / Salary records	Held by North East London Pay Consortium Retention calculated from termination of employment	10	Destroy

HUMAN RESOURCES / PERSONNEL			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Alert Letters	Alert Letters Policy HSC 2002/011, Annex 1	Retain until letter formally cancelled by Regional Director of Public Health	Destroy
Annual leave records	See Human Resources records – line manager's file		
Capability records on local / line manager's file – records of meetings	See Capability Policy and Procedure	Retain until warning period expired (warning period must be no more than 1 year)	Destroy
Disciplinary records on local / line manager's file - first written warning - final written warning / action short of dismissal - final written warning / action short of dismissal (involving serious patient related matters)	n.b. a copy of all these records is retained on the central Trust file. If employee is dismissed information should be sent to HR for filing with the central Trust file. See Disciplinary Policy for further guidance	 0.5 1 1.5	Remove and destroy all details from local file after required period
Duty rosters (clinical staff)		4	Destroy
Equal Opportunities Monitoring form		Destroy once information used for monitoring purposes	
Human resources records: - Central Trust file (includes job application, CV, job description, letters of appointment, contracts, references & related correspondence, registration authority forms, training records, criminal record checks, grievance records) - Summary of employment (MAPS or equivalent databases)		6 from staff leaving date 30 (or until 70th birthday)	Destroy Offer to Archives

HUMAN RESOURCES / PERSONNEL			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Human resources records – line manager's file: - timesheets - annual leave records, attendance records, sick leave records, return to work interviews, appraisals, personal development plans - study leave applications (for medical / clinical training)	For capability or disciplinary records See Capability or Disciplinary records (above)	 0.5 2 5	If staff transfers to new post within Trust, pass file to new manager after weeding out of date papers.
Industrial Relations / Tribunals (non routine staff matters)		10	Offer to Archives
Job advertisements / unsuccessful applications / recruitment notes	n.b. for Consultants See Recruitment of Consultants; for NEDS See non executive directors	1	Destroy
Job applications - successful	See Human Resources records – central Trust file		
Job descriptions	See Human Resources records – central Trust file		
Leavers records	See Human Resources records – central Trust file		
Non executive directors – CVs of successful applicants	Retention calculated from staff leaving date	5	Offer to Archives
Non executive directors – CVs of unsuccessful applicants		2	Destroy
Nurse Training records (clinical training to achieve Nursing qualification)		30	Offer to Archives
Occupational health records: - Health records for classified persons under medical surveillance - Personal exposure of an identifiable employee monitoring records - Personnel health records under occupational surveillance - Radiation dose records for classified persons	 Control of Substances Hazardous to Health Regulations 2002 Ionising Radiation Regulations 1999	 50 or age 75 40 from exposure 40 from last entry on record 50 or age 75	 Destroy Destroy Destroy Destroy

HUMAN RESOURCES / PERSONNEL			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Recruitment of Consultants	*The NHS (Appointment of Consultants) Regulations January 2005*	5	Destroy
Registers of staff (e.g. Nursing, Midwives)		Permanent	Transfer to Archives
Salaries	See Financial section - Payroll		
Staff rotas	See Duty rosters		
Staff car parking permits		3	Destroy
Study leave applications (for clinical / medical training)	See Human Resources records – line manager's file		
Timesheets	See Human Resources records – line manager's file		
Training plans – personal development plan	See Human resources records – line manager's file		

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Abortion – Certificate A (Form HSA1) and Certificate B (Emergency Abortion)	[Abortion Regulations 1991, Statutory Instrument No. 499]	3	Destroy
Accident & Emergency records		8 (adults) 25 (children)	Destroy
Accident & Emergency registers		8	Offer to Archives
Admission registers / books		8	Permanent - Transfer to Archives
Adoption records	Not Trust records – records belong to Local Authority		
Ambulance records	Not Trust records – records belong to Ambulance Service		
Anatomical records (e.g. records of bodies for dissections etc)	Refer to guidance in Pathology section.		
Angiograms	See also Radiographs	8	Destroy
Appointment Books		2	Destroy
Audio-tapes		8	Offer to Archives
Birth registers (i.e. register of births kept by the hospital)	See also Maternity registers	Permanent	Transfer to Archives when complete
Blood transfusion	See Pathology section		
Body release forms	See also Mortuary	2	Destroy
Breast screening X-rays		8	Destroy
Child Protection Register (records relating to)		Retain until 26th birthday	Destroy
Clinical audit records		5	Destroy
Clinical research / research projects - research project / trial records: - research which did not start	Trust Executive Group 04/10/2006	20 2	Offer to Archives Destroy
Controlled drugs registers	See PHARMACY section		
Death registers (hospital registers)		Permanent	Transfer to Archives when complete
Death – Cause of Certificate counterfoils		2	Destroy
Diaries – clinical staff		2	Destroy

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Digital images	See Radiographs See also – x-rays See also - photographs		
Discharge books (registers of those discharged by the hospital)		8	Permanent - Transfer to Archives
Discharge summaries		8	Offer to Archives
Drug information records	See Pharmacy section		
Ethics	See Research Ethics Committee		
Family planning records		Adults: 10 Children: up to 25th birthday	Destroy
Film & Video recordings	See Videos		
Health records: - pre-1948 - Microfilmed records		-	Offer to Archives
Health records - Children and young people (age 17 or younger)	Review for genetic / adult implications and retain for longer if advised by clinician.	Until patient's 26th birthday or 8 after death	Destroy
Health records - Clinical Psychology		30 or 8 after death	Offer to Archives
Health records - Creutzfeldt –Jakob Disease (CJD)	CJD incidents panel	30 after death	Offer to Archives
Health records - Counselling records		30 or 8 after death	Offer to Archives
Health records - Donor records (blood and tissue)	[Committee on Microbiological Safety of Blood and Tissues for Transplantation 1996]	30 (post trans-plantation)	Destroy
Health records - Patients with learning difficulties (if treatment relates to the learning difficulty)		10 after death	Destroy

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Health records - Maternity records (all obstetric and midwifery records including stillbirths)	Maternity records retained should include booking data, pre-pregnancy records, antenatal records, intrapartum and postnatal records, including prescriptions, clinical test results and scans *Joint Position of the Retention of Maternity Records* – British Paediatric Association et al	25 after birth of last child	Offer to Archives
Health records - Mentally disordered persons	[Mental Health Act 1983]	20 after end of treatment or 8 after death	Offer to Archives
Health records - Oncology (including radiotherapy)	Royal Coll. Of Radiologists recommend long-term retention of databases of patients receiving chemo/radio therapy [BFCO(96)3]	30 after end of treatment or death	Offer to Archives
Health records - Patients involved in clinical research projects / trials	See also Clinical research. Trust Executive Group 04/10/2006	15 after end of trial	Destroy
Health records - Psychology	See Health records - Clinical Psychology		
Health records - Notes of patients having committed suicide		10 after death	Offer to Archives

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Health records - All other health records not covered above, including: - Audiology - Care records - Child and Family Guidance - District Nursing records - Dietetic and Nutrition - Genito-Urinary Medicine - Intensive Care Unit Charts - Macmillan (cancer care) patient records – community and acute - Music Therapy - Orthoptic records - Physiotherapy record - Podiatry - Speech and language therapy - Ultrasound		8 (adults / deceased) or 25 (children) or 20 (mentally disordered person)	Destroy
Health visitor records		10 (adults) 25 (children)	Destroy
Hospital acquired infection records	See infection Control Policy	6	Destroy
Hospital patient case records	See Health records (above)		
Human fertilisation records, including embryology records: ***Treatment centre*** - Live child not born - Live child born - Outcome unknown ***Storage centre*** - Records of gametes etc used in research ***Research centre records***		 8 25 after birth 50 50 3 from report of results to HFEA	 Destroy Destroy Destroy Destroy Destroy
Incident reports / files	See Administration / Management section		
Indexes of patient records (including microfiche copies of PAS electronic index)		Retain as long as needed for reference	Offer to Archives

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Laboratory records	Should be held on main patient file. See also Pathology		
Lists / indexes of records destroyed in accordance with this schedule / records destruction log	BS ISO 15489 (9.10)	Permanent	Contract Modern Records Manager or Health Records Manager
Litigation (records / documents relating to)	Advice may be required from Litigation department	10	Offer to Archives
Maternity records	See Health records - Maternity		
Maternity registers	See also Birth Registers	Permanent	Transfer to Archives
Midwifery records	See also Health records	25 after birth of last child	Offer to Archives
Midwives registers of cases	In use to 1990s under Midwives Act 1936	Permanent	Transfer to Archives
Mortuary registers		5	Permanent - Transfer to Archives
Neonatal screening records		25	Destroy
Nursing records	See Nursing Documentation Policy	8	Contact Health Records about disposal
Notifiable diseases book		6	Destroy
Obstetric records	See Health records – Maternity		
Operating Theatre registers		8	Offer to Archives
Outpatient lists		2	Destroy
Parent or patient held records	At the end of an episode of care arrangements should be made to retrieve parent or patient-held records, which should then be retained by the Trust		
Pharmacy records – clinical trials records	See Clinical research		
Pharmacy records	See PHARMACY section		
Photographs – Medical (where photograph refers to a particular patient it should be treated as part of the health record)	See **BLT POL/01103/MED** *Code of Responsible Practice for Medical Illustration*	8 (adults) 25 (children) 8 (deceased)	Offer to Archives

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Prescriptions	See PHARMACY section		
Private patient records	Admissions under National Health Service Acts, 1946, 1977. See Health records.		
Prosthesis or implants (e.g. joint replacement, breast implants, hip replacement etc): records about the prosthesis or implant		10	Destroy
Radiographs – originals or photographs and slides	See **BLT POL/01103/MED** *Code of Responsible Practice for Medical Illustration*	8 (adults) 25 (children)	Offer to Archives
Research – projects or clinical trials	See Clinical research		
Research Ethics Committee - Applications	Trust Executive Group 04/10/06	20	Destroy
Research Ethics Committee – minutes of meetings, Chair's papers		5	Permanent – Transfer to Archives
Scans	See Radiographs		
Transplantation records - records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to organ transplantation	www.rcpath.org/resources/pdf/Retention-SEPT05.pdf	3	Destroy
Videos	See **BLT POL/01103/MED** *Code of Responsible Practice for Medical Illustration*	8 (adults) 25 (children) 20 (mentally disordered)	Offer to Archives
Ward diaries/message books		2	Destroy
Ward meetings notes	See Administration / Management section: Meeting papers		
Ward / nursing audits		6	Destroy
Ward pharmacy sheets	See Pharmacy section		
Ward registers/reports, including daily bed returns		2	Offer to Archives
X-ray films (including other image formats for all imaging modalities)	Royal College of Radiologists	7	Destroy
X-ray registers		30	Offer to Archives

PATIENT / HEALTH			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
X-ray reports (including reports for all imaging modalities)	Considered as a part of the main patient record See Health records		

PATHOLOGY			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Accreditation documents; records of inspections	www.rcpath.org/resources/pdf/retention-Sept05.pdf	10	Destroy
Batch records results	Consumer Protection Act 1987	10	Destroy
Day books and other records of specimens received by a laboratory		2	Destroy
Donor or recipient sera (records relating to)		11 post transplant	Destroy
Equipment / instruments maintenance logs, records of service inspections		Lifetime of equipment	Destroy
External quality control records		2	Destroy
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): - Post-mortem records which form part of the Coroner's report. - All other forensic records	Approval should be sought from the Coroner for a copy of the report to be incorporated into the patient's notes.	Retain as health record 30	Offer to Archives
Genetic records		3	Destroy
Indexes (card indexes)		Retain as long as required for reference	Offer to Archives
Internal quality control records	Consumer Protection Act 1987	10	Destroy
Investigation or storage of specimens relevant to organ transplantation, semen or ova (if not in patient health record)		30	Destroy
Lab file cards or other working records of test results for named patients		2	Destroy

PATHOLOGY			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Near-patient test data		Result filed in patient record; log retained for lifetime of instrument	Destroy
Pathological archive / museum catalogues		30	Permanent – Pathology Museum / Trust Archives
Photographic records (where images present the primary source of information for the diagnostic process)		30	Offer to Archives
Post Mortem registers / reports not in health record		30	Permanent - Transfer to Archives
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment		11	Destroy
Records of telephoned reports		2	Destroy
Request forms - That do not contain unique information - That contain clinical information not readily available in the health record		 1 wk after report received by requestor 30	 Destroy Offer to Archives
Standard Operating Procedures (current and old)		30	Offer to Archives
SPECIMENS AND PREPARATIONS			
Blocks for electron microscopy	Human Tissue Act	30	Destroy
Cervical screening slides	Human Tissue Act	10	Destroy
Electrophoretic strips and immunofixation plates: - Strip or plate itself - Digital images of strips or plates	Human Tissue Act	 5 2	 Destroy Destroy

PATHOLOGY			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Foetal serum	Human Tissue Act	30	Destroy
Frozen tissue for immediate histological assessment (frozen section): - Stained microscope slides - Residual tissue	Human Tissue Act	 10 kept as fixed specimen once frozen section complete	 Destroy Destroy
Frozen tissue or cells for histochemical or molecular genetic analysis	Human Tissue Act	10	Destroy
Grids for electron microscopy	Human Tissue Act	10	Destroy
Human DNA - Diagnostic specimens - Family studies for genetic disorders	Human Tissue Act	 4 wks after final report 30 (consent required)	 Destroy Destroy
Human tissue not mentioned elsewhere in this schedule.	Refer to Human Tissue Act		
Microbiological cultures	www.rcpath.org/resources/pdf/Retention-SEPT05.pdf Human Tissue Act	24-28 days after final report of a positive culture issues. 7 days for certain specified cultures – see RCPath document	Destroy
Museum specimens (teaching collections)	Consent of relative required if tissue obtained through post mortem Human Tissue Act (license may be required to retain)	Retain for usable life of specimen	Pathology Museum

PATHOLOGY			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Museum specimens – stained slides	www.rcpath.org/resources/pdf/Retention-SEPT05.pdf Human Tissue Act (license may be required to retain)	See RCPath document for details	Pathology Museum
Newborn blood spot screening cards Newborn body fluids / aspirates / swabs	Code of Practice of UK Newborn Screening Programme Centre www.screening.nhs.uk/cpd/ICFactsheet4.pdf Alert parents to possibility of contact from researchers and keep a record kept of their consent to contact response. Human Tissue Act	5 48 hrs after report issued	Destroy Destroy
Paraffin blocks	Human Tissue Act (license may be required to retain)	30	Pathology Archive / Trust Archives
Serum following needlestick injury or hazardous exposure	Human Tissue Act	2	Destroy
Serum from first pregnancy booking visit	Human Tissue Act	1	Destroy
Wet tissue (representative aliquot or whole tissue or organ)	Human Tissue Act	4 wks after final report for surgical specimens	Destroy
Whole blood samples, for full blood count	Human Tissue Act	24 hours	Destroy
TRANSFUSION LABORATORIES			
Annual reports (where required by EU Directive)		15	Offer to Archives
Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	Copies may only be lodged on the health record with the Coroner's permission	Retain as health records	Offer to Archives if not on health record

PATHOLOGY			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Blood bank register, blood component audit trail and fates	Full traceability of all blood products required. EU Directive 2002/98/EC. The Blood Safety and Quality Regulations 2005 (SI 2005 No.50)	30	Destroy
Blood for grouping, antibody screening and saving and/or cross-matching		1 week at 4 degrees C	Destroy
Forensic material – criminal cases	Not part of the health record	30	Offer to Archives
Refrigeration and freezer charts		11	Destroy
Request forms for grouping, antibody screening and cross-matching	EU Directive 2002/98/EC. The Blood Safety and Quality Regulations 2005 (SI 2005 No.50)	1 month	Destroy
Results of grouping, antibody screening and other blood transfusion-related tests	Full traceability of all blood products required. EU Directive 2002/98/EC. The Blood Safety and Quality Regulations 2005 (SI 2005 No.50)	30	Destroy
Separated serum/plasma stored for transfusion purposes		Up to 6 months	Destroy
Storage of material following analyses of nucleic acids	See RCPath document for further guidance www.rcpath.org/resources/pdf/Retention-SEPT05.pdf	30	Destroy
Worksheets	Full traceability of all blood products required. EU Directive 2002/98/EC. The Blood Safety and Quality Regulations 2005 (SI 2005 No.50)	30	Destroy

PHARMACY Hospital Pharmacists Group 2003 www.pjonline.com/pdff/hp/200305/hp_200305_pharmacyrecords.pdf			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
MEDICINES INFORMATION			
Enquiry records		10 (adults) 25 (children, maternity)	Destroy
PRESCRIPTIONS			
Chemotherapy		2	Destroy
Clinical drug trials	See Patient / Health - Clinical Research. File should be sent to Trust records centre for storage with all other records from the trial		
Error records (dispensing)		1	Destroy
FP10, TTOs, outpatient, private, discharge letter, log sheets	n.b. inpatient prescriptions held as part of health record	2	Destroy
Parenteral nutrition	n.b. original valid prescription to be held with health record	2	Destroy
Unlicensed medicines dispensing record		5	Destroy
WORKSHEETS			
Raw material request and control form		5	Destroy
Resuscitation box	Applies only to repackaged items	1 yr after expiry of longest dated item	Destroy
Worksheets: Chemotherapy, CIVAS, non sterile, radiopharmacy, sterile manufacturing, external hospitals, aseptics worksheets, parenteral nutrition, production batch records	Product liability extends up to 11 years after expiry	5	Destroy
Worksheets: Paediatric	Product liability extends up to 28 years after expiry	25	Destroy
QUALITY ASSURANCE			
Audit reports		3	Destroy
Change control forms		3	Destroy
Change control non-compliance forms		5	Destroy

PHARMACY Hospital Pharmacists Group 2003 www.pjonline.com/pdff/hp/200305/hp_200305_pharmacyrecords.pdf			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Environmental monitoring results		3 or 1 year after expiry date of products, whichever is longer	Destroy
Error records		1	Destroy
Equipment validation		Lifetime of equipment + 3	Destroy
External validation of facility		3	Destroy
QA batch records: batch sheets, batch books and recalls / drug alerts		5	Destroy
QC documentation, certificates of analysis	Article 51(3) Directive 2001/83	5 or 1 year after expiry of batch (whichever is longer)	Destroy
Refrigerator temperature	Refrigerator records to be retained for the life of any product stored therein	1	Destroy
Standard operating procedures / policies		15 (after superseded)	Offer to Archives
Test data - reagent preparation forms - TPN Electrolyte test data		 3 5	 Destroy Destroy
Validation of operators	Hold on staff file, for audit	3 after employment terminated	Destroy
ORDERS / PRODUCTION			
Invoices	Retention calculated from end of financial year	6	Destroy
Order and delivery notes, requisition sheets, old order books	Retention calculated from end of financial year	2	Destroy
New products requests / specification		5	Destroy
Picking ticket / delivery notes		3 months	Destroy

PHARMACY Hospital Pharmacists Group 2003 www.pjonline.com/pdff/hp/200305/hp_200305_pharmacyrecords.pdf			
Type of record	**Notes**	**Retain (Years)**	**Final Action**
Procurement: correspondence & other supplies documentation		0.5	Destroy
Re-packs and over-labels		2	Destroy
Stock control: stock check lists		1	Destroy
Ward pharmacy requests / please supply form / ward issue sheets / IS forms	Limitation Act 1980	1	
CONTROLLED DRUGS			
Controlled drug audit records		2	Destroy
Controlled drug destruction records (pharmacy and ward based)	Misuse of Drug Regulations 2001	2	Destroy
Controlled drug prescriptions (TTOs/OP)	Misuse of Drug Regulations 2001	2	Destroy
Controlled drug order books, ward orders and requisitions	Misuse of Drug Regulations 2001	2	Destroy
Controlled drug registers (pharmacy and ward based)	Misuse of Drugs Act 1971 and Misuse of Drug Regulations 2001	2	Destroy

APPENDIX B

PROPOSAL TO CHANGE TRUST RETENTION SCHEDULE OR DISPOSE OF RECORDS

All disposals of records must be in accordance with the Trust Records Retention Schedule in Appendix A of the Trust Records Retention Policy. This template must be completed and submitted to the Information Governance Steering Group for consideration, when proposing to:

A) CHANGE THE TRUST RETENTION SCHEDULE
i.e. amend the Trust Records Retention Policy to change the retention period for a whole series of records.

OR

B) DISPOSE OF A SPECIFIC COLLECTION OF RECORDS IN A WAY CONTRARY TO THE RETENTION SCHEDULE
i.e. destroy a specific collection of records as a one-off disposal: when the records have not yet reached the end of the appropriate retention period, or if it is not known whether they have reached the end of the appropriate retention period.

An editable version of this document is available from the Modern Records Manager.

1. Type of proposal

1.1	**Is this proposal to:** **A Change the Trust Retention Schedule** **OR** **B Dispose of a specific collection of records in a way contrary to the retention schedule (this would normally be a single, unique disposal where special circumstances would apply)**

2. Type of Record

2.1	**Title / name of the records series**
2.2	**Format (e.g. microfilm, microfiche, paper files, electronic)**
2.3	**Describe the type of information / data / content contained within the records (e.g. personal data, medical information, financial data, minutes, Etc.)**

2.4	**Is any of this information available from other sources / duplicated? If so, describe how. (e.g. duplicated in other records, summarised in other records, listed on a database, converted into another format? (electronic, cd-rom) etc.)**
2.5	**Date range of records (earliest and latest date: either date of record or date of birth)**
2.6	**How has the date range been identified? (e.g. has a sample been analysed or is this an assumption? Give details, e.g. percentage of records analysed).**
2.7	**Location of records**
2.8	**Volume (e.g. number of boxes, shelves, filing cabinets, meterage, size)**
2.9	**Directorate / Department responsible**
2.10	**Contact person (name and job role)**
2.11	**Is there a finding aid? (e.g. list or database of the records)**

3. Reason for proposed change of retention policy or disposal

3.1	**Please provide a brief summary / explanation below.**

4. Staff who have been consulted about the proposal

4.1	**List names and job titles of those consulted. Include comments if useful.**

5. Retention requirements

5.1	**What is the current retention period for these records?**
5.2	**Why is this the current retention period? List all that apply:** • **Trust Retention Policy** • **Historical practice** • **Best practice / professional guidelines** • **Department of Health *NHS Records Management: Code of Practice* (2006)** • **Legislation** • **Other (please explain)**
5.3	**(If applicable) What is the proposed new retention policy? Specify:** **i) number of years to be retained** **ii) how this is to be calculated (e.g. from date of birth of patient or last date of papers in file, etc)** **iii) action to be undertaken at end of retention period (e.g. Destroy / Review records / Offer to Trust Archivist)**

6. Retention consideration: Business purposes / information

6.1	**How long is the record needed as a source of information to support current administration, public service, economic activity or other dealings between individuals and the Trust?**
6.2	**How long does the activity supported by the record continue?**
6.3	**How long will records be needed after the event to which they relate has finished?**
6.4	**Are the records ever referred to for another purpose than which they were created? (e.g. compilation of annual reports, gathering of statistics, Data Protection / Subject Access Requests etc).**

7. Retention consideration: evidential / accountability

7.1	**Is there a legal requirement to retain the record for a specific period of time?**

7.2	**Are there any other regulations or best practice requirements which specify a retention period?**
7.3	**What are the audit requirements? (financial audits, other internal and external inspections)**
7.4	**How long is the record required to enable the Trust to provide a response to challenge? (legal defence and handling of internal and external grievances or complaints)**
7.5	**How long is the record needed as evidence of activities or decisions / to prove that Trust has complied with legal or regulatory requirements or recognised best practice?**
7.6	**Include any examples known of when the records were needed for legal cases.**

8. Retention consideration: historical / archival

8.1	**Do the Trust Archivists require the record for permanent archival preservation / research?**
8.2	**Are there any other purposes for which the records might be used, e.g. teaching, research?**

9. Needs of external users

9.1	**Do members of the public / external users have an interest in how long the records are retained?**
9.2	**What is the practice of other Trusts (give examples where known)?**

10. Storage / Maintenance / Cost issues

10.1	**Has alternative accommodation been considered?**

10.2	**What would be the cost of continuing to store them? (e.g. accommodation, equipment, staffing, conversion to other format)**
10.3	**Are there any health and safety issues?**
10.4	**Does the format / media in which the record is currently stored deteriorate over time?**

11. Accessibility

11.1	**Can the records be accessed? (describe any issues or problems here. For patient records, has PAS or Old PAS been checked?)**
11.2	**If not, what would be necessary for the records to be accessible? (describe any work and resources necessary to list records or re-file records, etc).**
11.3	**How often / how regularly have they been accessed so far?**

12. Risk / Litigation

12.1	**Have Risk Management / Litigation been consulted? Provide evidence**
12.2	**What are the possible consequences of the absence of the records? (fines, inability to defend legal action, disruption, reputation / goodwill).**
12.3	**What is the severity of the possible consequence(s) including likely penalties for the Trust if it cannot produce the records?**
12.4	**What is the likelihood of legal proceedings or other events which will require the production of the records?**
12.5	**What would be the financial implications if the records have to be replaced or reconstructed?**

13. Other Trust Policies and Guidance

13.1	**Does the proposal conflict with any other Trust Policies? e.g.:** • **Health Records and Surgery Policy** • **Good Health Record Keeping Guidelines** • **Medical Illustration: Code of Responsible Practice** • **Data Protection Policy** • **Freedom of Information Policy** • **Data Quality** • **Information Security**
13.2	**Are there any similar records held by the Trust which may be affected by the proposed change to the retention period? Consider any inconsistencies which might arise if similar information is retained for differing periods across the Trust.**

14. Other users

14.1	**Do any other departments / sections of the Trust make use of the information in the records?**
14.2	**Have you considered whether the proposal will impact upon any other department / record users?**

15. Proposal drawn up by:

15.1	**List name(s) and job title(s)**
15.2	**Date completed**

This proposal should be submitted to the Information Governance Steering Group for consideration. Please contact the Modern Records Manager or Information Governance Manager for advice.

16. For completion by Modern Records Manager:

16.1	**Proposal discussed / approved / rejected at (record details):**
16.2	**Evidence of decision is at (list document in which decision is documented e.g. minutes of meeting)**

Paperwork relating to the policy change or disposal of records will be held by the Modern Records Manager.

If this proposal is approved and records destroyed as a result, a list of the records should be provided to the Modern Records Manager.