East London NHS
NHS Foundation Trust

Records Management: NHS Code of Practice

Records Retention and Disposal Schedules

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Annex D: Notes to Accompany the NHS Records Retention and Disposal Schedules

1. Introduction

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

The Annex provides information and advice about all records commonly found within NHS organisations. For ease of use, there are separate schedules relating to health and corporate (ie non-health) records. The retention schedules apply to all the records concerned, irrespective of the format (eg paper, databases, e-mails, X-rays, photographs, CD-ROMs) in which they are created or held.

To help Records Managers differentiate between existing and new categories of records, and unchanged or changed/new retention periods, the following keys have been used:

2. Responsibilities and Decision Making

Records of the NHS and its predecessor bodies are subject to the Public Records Act 1958, which imposes a statutory duty of care directly upon all individuals who have direct responsibility for any such records.

For an NHS organisation to manage its records effectively, wider records management responsibilities need to be considered, placed with the appropriate individuals and/or committees, and resourced. For example, organisations may require local records managers and/or a corporate records manager; a health or medical records manager and/or committee; and possibly an archivist.

Requirements for records management are set out in more detail elsewhere in the Code of Practice and in the Information Governance Toolkit. If overall responsibility has not already been allocated, it is recommended that this should be placed with the NHS organisation's Information Governance Committee.

3. Interpretation of the Schedules

TYPE OF RECORD: lists alphabetically records created as part of a particular function. The business and corporate records schedule has grouped together records of major functions commonly found in NHS organisations.

MINIMUM RETENTION PERIOD: records are required to be kept for a certain period either because of statutory requirement or because they may be needed for administrative purposes during this time. If an organisation decides that it needs to keep records longer than the recommended minimum period, it can vary the period accordingly and record the decision and the reasons behind it, on its own retention schedule. Records which have been selected for permanent preservation by the relevant place of deposit should normally be transferred there as soon as they reach the retention period specified and in any case before they reach 30 years old, unless a longer operational retention period is specified in this Code, in which case transfer should take place as soon as possible after this period has been reached. NHS organizations wishing to keep records more than 30 years old for operational reasons beyond the minimum period specified in this Code should consult The National Archives for advice. Note that transfers of selected records to places of deposit will be covered by Condition 7(1) of Schedule 3 and s.33 of the Data Protection Act 1998.

DERIVATION: notes the details of legislation and any other references of relevance to the recommended minimum retention period.

FINAL ACTION: at the end of the relevant minimum retention period, one or more of the following actions will apply:

1) Review: records may need to be kept for longer than the minimum retention period due to ongoing administrative need. As part of the review, the organisation should have regard to the fifth principle of the Data Protection Act 1998, which requires that personal data is not kept longer than is necessary. If it is decided that the records should be retained for a period longer than the minimum (provided that this does not total a period of 30 years or more from creation, in which case see the comments on the minimum retention period above), the internal retention schedules will need to be amended accordingly and a further review date set. Otherwise, one of the following will apply:

2) Transfer/consult a Place of Deposit or The National Archives (see 'Archives' section below): if the records have no ongoing administrative value but have or may have long-term historical or research value, or they have some administrative value but are more appropriately held as archives. Records with such value must be transferred to the organisation's approved Place of Deposit. Where the organisation has no existing relationship with a Place of Deposit, The National Archives should be contacted in the first instance. Where an organisation is unsure whether records may have archival value, The National Archives or the Place of Deposit with which the organisation has an existing working relationship should be consulted.

3) Destroy: where the records are no longer required to be kept due to statutory requirement or administrative need and they have no long-term historical or research value. In the case of health records, this should be done in consultation with clinicians in the organisation (see section 5 below).

NOTE: NHS organisations have a legal responsibility to maintain records safely and securely under Principle 7 of the Data Protection Act. Patients can gain a copy of their record by making a subject access request under DPA, but should not normally be provided with original record itself (even if it has reached the end of the recommended retention period and is due for destruction) unless the permission of the Lord Chancellor has been obtained in accordance with s.3(6) of Public Records Act. More information on the operation of s.3(6) can be obtained from The National Archives.

4. Retention Periods

As previously stated, records should not ordinarily be kept for longer than 30 years. The Public Records Act does, however, provide for records, which are still in current use to be legally retained. Additionally, under separate legislation, records may be required to be retained for longer than 30 years (eg Control of Substances Hazardous to Health Regulations). The minimum retention periods should be calculated from the beginning of the year after the last date on the record. For example, a file in which the first entry is in February 2001 and the last in September 2004, and for which the retention period is seven years, should be kept in its entirety at least until the beginning of 2012.

Each organisation should produce its own retention schedules in the light of its own internal requirements. Organisations should not apply to any records a shorter retention period than the minimum set out in these schedules, but there may be circumstances in which they need to apply a longer retention period. Any decision to extend must ensure that the retention period does not exceed 30 years unless prior approval has been obtained via The National Archives.

Also, in respect of any records that contain personal data as defined by the Data Protection Act, consideration should be given to the fifth principle of the Act, ie that 'Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes'. Note that transfers of selected records to places of deposit will be covered by Condition 7(1) of Schedule 3 and s.33 of the Data Protection Act 1998.

5. Who Makes the Decision Regarding Disposal and Destruction of Records?

There are two principal options: to dispose (eg by passing on to another organisation) or to destroy. Staff in the operational area that ordinarily uses the records will usually be able to decide. Operational managers are responsible for making sure that all records are periodically and routinely reviewed to determine what can be disposed of or destroyed in the light of local and national guidance.

In respect of health records, it is recommended that a multi-disciplinary Health Records Committee and/or Health Records User Group should be established to provide advice on local policy, particularly for the retention, archiving or disposal of sensitive personal health records. Input from local healthcare professionals should be a key element of any records management strategy.

Once the appropriate minimum period has expired, the need to retain records further for local use should be reviewed periodically. Because of the sensitive and confidential nature of such records and the need to ensure that decisions on retention balance the interests of professional staff, including any research in which they are or may be engaged, and the resources available for storage, it is recommended that the views of the profession's local representatives should be obtained.

Although this Code of Practice contains a comprehensive list in regards to record type and category in the retention schedules, it is not possible to list every type. Where a record type is not listed record holders/managers should consider how other organisations manage these record types and should carry out a risk assessment of the pros and cons of destroying the record or maintaining it for a prolonged period in order to decide how best to manage the record.

Attention should also be paid to other retention periods for similar record types. The decision process around why a particular record type may be maintained or destroyed should be clearly documented.

6. Archives

It is a legal requirement that NHS records which have been selected as archives should be held in a repository that has been approved for the purpose by The National Archives. Where an organisation is already in regular contact with its Place of Deposit, it should consult with it over decisions regarding selection and transfer of records. Where this is not the case, The National Archives should be contacted in the first instance.

Some individual hospitals have themselves been appointed as a Place of Deposit. In practice these have tended to be those larger hospitals that can commit the resources necessary to provide appropriate conditions of storage and access, and to place them under the care of a professionally qualified archivist. However, it is open to any NHS organisation to apply for Place of Deposit status. The National Archives can provide further advice on this matter, and further information about the work of archivists in NHS organisations is available from the Health Archives Group.

Where possible, the schedules identify those records likely to have permanent research and historical value. Beyond this, some NHS organisations will have particular and individual reasons, which relate to their own history, for retaining particular records as archives. Conversely, it should also be borne in mind that some records may have a long-term research value outside the NHS organisation that created them (eg both administrative and clinical records from a number of different hospitals have been used to study the 1918 influenza epidemic). The Health Archives Group will advise on the current and potential research uses of NHS archives, including patient records.

Annex D1: Health Records Retention Schedule

This retention schedule details a **Minimum Retention Period** for each type of health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. Where a retention period longer than 30 years is required (eg to be preserved for historical purposes), or for any pre-1948 records, The National Archives (see note 1 below) should be consulted. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

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

- patient health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;

- Accident & Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (ie microfiche/microfilm);audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents.

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

Notes

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

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

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

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

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

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

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

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Trust (including information on an individual's educational status, care needs, etc)	young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation			
Cervical screening slides	10 years		Destroy under confidential conditions	S
Chaplaincy records	2 years		Likely to have archival value. See note 1	S
Child and family guidance	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Child Health Record	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, **or** 8 years after death. If the illness or death could have potential		Destroy under confidential conditions	N

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Clinical audit records	5 years		Destroy under confidential conditions	S
Clinical Protocol (GP, in-house)	25 years		Destroy under confidential conditions	N
Clinical psychology	20 years		See note 1	C
Clinical trials (see research records)				
Contraception and Sexual Health Records (Including where a scan is undertaken prior to termination of pregnancy but the patient goes elsewhere for the procedure)	8 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is		N

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		2004 NB “Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient’s medical records or in a case-file….” These records are subject to the retention periods in this schedule		
Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis, *including deceased patients*	CJD Incidents Panel	See note 1	S
Death – Cause of, Certificate counterfoils	2 years		Destroy under confidential conditions	S
Death registers – ie register of deaths kept by the hospital, where they exist in paper format	Lists sent to GRO on a monthly basis. Retain for 2 years Death registers prior to lists sent to GRO – offer to Place of Deposit		Likely to have archival value. See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Dental epidemiological surveys	30 years		Destroy under confidential conditions	S
Dental, ophthalmic and auditory screening records including Orthodontic Records and Models	*Community Records* 11 years for adults For children 11 years or up to their 25th birthday, whichever is the longer *Hospital Records* Adult records – Retain for 8 years Children and young people – Retain until the patient's 25th birthday or26th if young person was 17 at conclusion of treatment, **or** 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period	British Dental Association	Destroy under confidential conditions	N
De-registered patients (received by PCT's) – records for	Records for de-registered patients, which are received by the PCT, should be retained for at least 10 years. After the retention period has elapsed a decision must be taken by the PCT as to whether to destroy the records or retain them further.		Destroy under confidential conditions	N
Diagnostic Image Data (for diagnostic imaging undertaken in	Retain for the life of the National Diagnostic Imaging Services Contract and then return the data to the NHS after which the retention period in this retention schedule	National Diagnostic Imaging Services Contract; Records		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
the private sector under contract to the NHS or private providers treating patients on behalf of the NHS)	will apply.	Management: NHS Code of Practice		
Diaries – health visitors, district nurses and Allied Health Professionals	2 years after end of year to which diary relates. Patient specific information should be transferred to the patient record. Any notes made in the diary as an 'aide memoire' must also be transferred to the patient record as soon as possible.		Destroy under confidential conditions	N
Did not attend (DNA) see DNA below				
Dietetic and nutrition	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Discharge books	8 years after the last entry		Likely to have	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
(where they exist in paper format)			archival value. See note 1	
Discharge nursing team assessments of homes and nursing homes NB The documents should be part of the patient record as they relate to the discharge of the patient	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation			N
District nursing records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
DNA (health records for patients who **did not attend** for appointments as out-patients)	Where there is a letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given, so this information is also held elsewhere. Retain for 2 years after the decision is made. Where there is **no** letter or correspondence informing the		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation.			
Donor records (blood and tissue)	30 years post transplantation	Committee on Microbiological Safety of Blood and Tissues for Transplantation (MSBT); guidance issued in 1996	See note 1	S
Drug trials, records (see Research records)				
Duplicate patient record notification forms (NHS Direct)	2 years after the decision of whether or not to merge unless there is a business need to retain for longer.		Destroy under confidential conditions	N
Electrocardiogram	7 years		Destroy under confidential	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
(ECG) Records	NB Each chart should be labelled with the patient's name and unique identifier. Any over-sized charts could then be stored separately where a report is written into the health records.		conditions	
Endoscopy Records including: Sterilix Endoscopic Disinfector Traceability Strips, Traceability Stickers for PEG/Stents (Endoscopy)	Retain for standard retention periods i.e. 8 years for adults and in the case of children and young people retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, **or** 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period.		Destroy under confidential conditions	N
Family planning records (See also Contraception and Sexual Health Records)	For records of adults – retain for 10 years after last entry For clients under 18 – retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years	Destroy under confidential conditions	C
Forensic medicine records (including pathology, toxicology,	For post-mortem records which form part of the Coroner's report, approval should be sought from the coroner for a copy of the report to be incorporated in the patient's	*The Retention and Storage of Pathological Records and Archives*	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years	(3rd edition 2005) guidance from the Royal College of Pathologists and the Institute of Biomedical Science: http://www.rcpath.org.uk/resources/pdf/retention-SEPT05.pdf Human Tissue Act 2004		
Genetic records	30 years from date of last attendance	The Royal College of Pathologists endorses the Code of Practice and Guidance of the Advisory Committee on Genetic Testing (1997) and its recommendations on storage, archiving and disposal of specimens and records related to human testing services (genetics) offered and supplied direct to the public. Those who intend to offer such services should follow its guidance	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Genito Urinary Medicine (GUM) Includes sexual health records	For records of adults - retain for 10 years after last entry For clients under 18 - retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists	Destroy under confidential conditions	C
GP records, including medical records relating to HM Armed Forces or those serving a period of imprisonment	GP Records, wherever they are held, other than the records listed below retain for 10 years after death or after the patient has permanently left the country unless the patient remains in the European Union. In the case of a child if the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period Maternity records – 25 years after last live birth	 Limitation Act 1980, Congenital Disabilities (Civil Liability) Act 1976,	Destroy under confidential conditions Destroy under confidential conditions	S S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		Consumer Protection Act 1987		
	Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983 –20 years after the date of the last contact; **or** **10** years after patient's death if sooner NB GPs may wish to keep mental health records for up to 30 years before review. They must be kept as complete records for the first 20 years but records may then be summarised and kept in summary format for the additional 10-year period	Royal College of Psychiatrists	Destroy under confidential conditions	S
	Records relating to those serving in HM Armed Forces – The Ministry of Defence (MoD) retains a copy of the records relating to service medical history. The patient may request a copy of these under the Data Protection Act (DPA), and may, if they choose, give them to their GP. GPs should also receive summary records when ex-Service personnel register with them. What GPs do with them then is a matter for their professional judgement, taking into account clinical need and DPA requirements – they should not, for example, retain information that is not relevant to their clinical care of the patient		Not to be destroyed. This refers to GP records of serving military personnel that were inexistence prior to them enlisting. Following the death of the patient, the records should be retained for 10 years after their death.	S
	Records relating to those serving a prison sentence See also Prison Health Records (below) for guidance on scanning of hospital letters		Not to be destroyed. This refers to GP records of serving	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
			prisoners that were in existence prior to their imprisonment. After their death, the records should be retained for 10 years.	
	Electronic patient records (EPRs) must not be destroyed, or deleted, for the foreseeable future	Good Practice Guidelines for General Practice Electronic Patient Records (version 3.1)	Destroy under confidential conditions	S
Health visitor records	10 years. Records relating to children should be retained until their 25th birthday		Destroy under confidential conditions	S
Homicide/'serious untoward incident' records	30 years		See note 1	S
Hospital acquired infection records	6 years		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Hospital records (i.e. other non-specific, secondary care records that are not listed elsewhere in this schedule)	8 years after conclusion of treatment or death		Destroy under confidential conditions	N
Human fertilisation records, including embryology records	**Treatment Centres** The following retention periods apply to data held by clinics as established by HFEA Direction D 1992/1: 1. Where it is known that a birth has resulted from treatment – 25 years after the child's birth. 2. Where it is known that no birth has resulted from treatment – 8 years after conclusion of treatment. 3. Where the outcome of treatment is unknown – 50 years after the information was first recorded.	HFEA Data Protection Policy Version 2 Release Date 27/07/2007 http://www.hfea.gov.uk/docs/DP_Policy_-_web.pdf	See note 1	S
	Storage centres Where gametes, etc have been used in research, records must be kept for at least, 50 years after the information was first recorded	Directions given under the Human Fertilisation and Embryology Act 1990, 24 January 1992 (this Act is subject to review by the Government: http://www.dca.gov.uk/StatutoryBars Report2005.pdf)		S
	Research centre	This applies to centres		S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	in respect of information which they are directed to record and maintain under a treatment/storage licence.		
Human tissue (within the meaning of the Human Tissue Act 2004) (see Forensic medicine above)	For post mortem records which form part of the Coroner's report, approval should be sought from the Coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed All other records retain for 30 years		See note 1	S
Immunisation and vaccination records	For children and young people – retain until the patient's 25th birthday or 26th if the young person was 17 at conclusion of treatment All others retain for 10 years after conclusion of treatment		Destroy under confidential conditions	S
Intensive Care Unit charts	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Joint replacement	10 years	http://www.njrcentre.org.	See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
records	For joint replacement surgery the revision of a primary replacement may be required after 10 years and there is a need to identify which prothesis was used originally. There is only a need to retain the minimum of notes with specific information about the original prosthesis for the full 10 years	uk Consumer Protection Act (CPA) 1987 & Section 11A(3) Limitation Act 1980 (in accordance with Section 4 CPA)		
Learning difficulties – (records of patients with) NB Specific Learning Difficulty is where a person finds one particular thing difficult but manages well in everything else	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died whilst in the care of the organisation	Royal College of Psychiatrists	Destroy under confidential conditions	C
Learning Disabilities NB A general learning disability is not a mental illness – it is a life-long condition, which can vary in degree from mild to profound	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died whilst in the care of the organisation	Royal College of Psychiatrists	Destroy under confidential conditions	N
Macmillan (cancer care) patient records– community and acute	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation			
Mammography Screening (mammograms and reports)	Normal Packet – *9 years after date of final attendance* Screen detected cancers – *Indefinitely* Interval Cancers – *Indefinitely* Interesting Cases – *Indefinitely* Research Cases – *15 years after date of final attendance* Age Trial Cases – *9 years after date of final attendance* Deaths – *9 years after date of final attendance* Where product liability is involved – *11 years* NB Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record	BFCR(06)4 Royal College of Radiologists Consumer Protection Act 1981	Destroy under confidential conditions	N
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child	See Addendum 1 (*Joint Position on the Retention of Maternity Records*) devised by: British Paediatric Association, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, and the	Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		United Kingdom Central Council for Nursing, Midwifery and Health Visiting		
Medical illustrations (see Photographs below)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Mental Health Records – Child & Adolescent (includes clinical psychology records) not listed elsewhere in this schedule	20 years from the date of last contact, or until their 25th/26th birthday, whichever is the longer period. Retention period for records of deceased persons is 8 years after death.		Destroy under confidential conditions	N
Mentally disordered persons (within the meaning of any Mental Health Act)	20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, **or** 8 years after the death of the patient/client/service user if sooner NB Mental health organisations may wish to keep mental heath records for up to 30 years before review (local	Mental Health Act 1983 and its successors Royal College of Psychiatrists	When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	decision). Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. This retention period has been intentionally left flexible to allow organisations to determine locally in collaboration with clinicians which option to follow as some organisations have storage problems and are unable to retain for longer than 20 years. The records of all mentally disordered persons (within the meaning of the MH Act) are to be retained for a minimum of 20 years irrespective of discipline e.g. Occupational Therapy, Speech & Language Therapy, Physiotherapy, District Nursing etc) Social services records are retained for a longer period. Where there is a joint mental health and social care trust, the higher of the two retention periods should be adopted		review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review	
Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		May have archival value. See note 1	S
Midwifery records	25 years after the birth of the last child	*Midwives rules and standards* 05.04 (rule 9)	Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Mortuary registers (where they exist in paper format)	10 years		See note 1	S
Music therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Neonatal screening records	25 years		Destroy under confidential conditions	S
Nicotine Replacement Therapy (dispensed as smoking cessation aid)	2 years unless there are clinical indications to keep them for longer		Destroy under confidential conditions	N
Notifiable diseases book	6 years		Destroy under confidential	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
			conditions	
Occupational health records (staff)	3 years after termination of employment unless litigation ensues (see Litigation)		Destroy under confidential conditions	S
Health records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Control of Substances Hazardous to Health Regulations 2002 (reg. 24(3))	See note 1	S
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	See above (reg. 10(5))	See note 1	S
Personnel health records under occupational surveillance	40 years from last entry on the record	Ionising Radiation Regulations 1999 (reg. 11(3))	See note 1	S
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	See above (reg. 19(3)(a))	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Occupational therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Occupationally Related Diseases e.g. asbestosis, pneumoconiosis, byssinosos)	10 years after date of last entry in the record	British Thoracic Society's Occupational and Environmental Lung Disease Specialist Advisory Group	Destroy under confidential conditions	N
Oncology (including radiotherapy)	30 years The 30 year retention period is the period required by the Public Records Act whereby organisations, which need to retain records for greater than 30 years should consult with their Local Place of Deposit (see note 1 – final action column). For deceased patients records should be retained for 8 years after death. NB Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes	BFCO (96)3 issued by the Royal College of Radiologists with the support of the Joint Council for Clinical Oncology	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Operating Theatre Lists (paper)	4 years (for those lists that only exist in paper format and are the sole record) 48 hours (for prints taken from computer records)			N
Operating theatre registers	8 years after the year to which they relate		Likely to have archival value. See note 1	S
Orthoptic records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions	S
Paediatric records (see Children and young people above)				
Parent-held records	At the end of an episode of care the NHS organisation		Destroy under	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
(i.e. records for sick/ ill children being cared for at home by community teams NOT the records of newborn children. These records are NHS records that belong to clinical staff but which are held by the parent.	responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve parent-held records. The records should then be retained until the patient's25th birthday, or 26th birthday if the young person was 17 at the conclusion of treatment, **or** 8 years after death		confidential conditions	
Pathology records *Documents, electronic and paper records* Accreditation documents; records of inspections	10 years or until superseded	http://www.rcpath.org/resources/pdf/retention-SEPT05.pdf The retention schedules are under review by the Royal College of Pathologists – check RCP website for updates	Destroy under confidential conditions	S
Batch records results (relating to products)	10 years	Consumer Protection Act 1987		N
Blood gas results	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation			
Bound copies of reports/records, if made	30 years			S
Day books and other records of specimens received by a laboratory	2 calendar years			S
Equipment/instruments maintenance logs, records of service inspections	Lifetime of equipment			S
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years			S

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

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

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

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

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
laboratories Annual reports (where required by EU directive)	15 years			S
Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records – copies may only be lodged on the health record with the Coroner's permission			S
Blood bank register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive N 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4ºC			S
Forensic material – criminal cases	Permanently, not part of the health record			S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Refrigeration and freezer charts	11 years			S
Request forms for grouping, antibody screening and crossmatching	1 month	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Separated serum/plasma, stored for transfusion purposes	Up to 6 months			S
Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	http://www.cepath.org/esources/pdf/Retention-SEPT05.pdf		S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Worksheets	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		S
Patient-held records	At the end of an episode of care the NHS organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve patient-held records. The records should then be retained for the period appropriate to the specialty		Destroy under confidential conditions	S
Pharmacy records *Prescriptions* Chemotherapy	Recommendations for the retention of pharmacy records (prepared by the NHS East of England Senior Pharmacy Manager's Network). Notes at the beginning of the retention schedule. 2 years after last treatment (Electronic Patient Records will eventually hold all details)	http://www.pjonline.com//news/recommendations_for_the_retention_of_pharmacy_records	Destroy under confidential conditions	S
Clinical drug trials (non-sponsored)	2 years after the end of the trial			S
FP10, TTOs, outpatient, private	2 years (Electronic Patient Records will eventually hold all details)		NB Inpatient prescriptions held	N

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Paediatric	At least 5 years See Note 6, Appendix ii)	Product liability extends up to 28 years		S
Quality Assurance Environmental monitoring results	1 year after expiry date of products As electronic record – in perpetuity			S
Equipment validation	Lifetime of the equipment			S
Quality Control documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	Article 51(3) Directive 2001/83		S
Refrigerator temperature	1 year (Refrigerator records to be retained for the life of any product stored therein, particularly vaccines)			S
Standard operating procedures	15 years As electronic record – in perpetuity			S
Orders Invoices	6 years See Note 4, Appendix ii)	Limitation Act 1980		S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Order and delivery notes, requisition sheets, old order books	2 years Current financial year plus one See Note 4, Appendix ii)			S
Picking tickets/delivery notes	3 months (i.e. a "reasonable period" – for verification of order only)			S
Ward pharmacy requests	1 year (Record of what was requested by ward pharmacist – unlikely benefit after 12 months)	Limitation Act 1980		S
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record) NB In the context of the Code of Practice a 'photograph' is a print taken with a camera and retained in the patient record.	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation Unless there is a clinical reason for retaining the digital image and a print is placed on the patient's record, there is no requirement to retain the digital image.		Destroy under confidential conditions	N
Physiotherapy	Retain for the period of time appropriate to the		Destroy under	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
records	patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		confidential conditions	
Podiatry records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Post mortem records (see Pathology records)				
Post mortem registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	S
Prison healthcare records (see also GP	Where hospital letters for serving prisoners are scanned into the Prison Health computer system and the paper		Destroy under confidential	C

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		for Counselling and Psychotherapy (BACP) 2004 NB "Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient's medical records or in a case-file……" These records are subject to the retention periods in this schedule		
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		See note 1	S
Records of destruction of individual health records (case notes) and other health-related records contained in this retention schedule (in manual or computer format)	Permanently	BS ISO 15489 (section 9.10)	See note 1	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Recovery Room Registers (Operating Theatre)	8 years	May have archival value. See note 1	Destroy under confidential conditions	N
Referral letters (for patients who are treated by the organisation to which they were referred)	Referral letters should be filed in the patient/client service user's health record, which contains the record of treatment and/or care received for the condition for which the referral was made. This will ensure that the patient record is a complete record. These records should then be retained for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Referral letters for clients referred to health or care services but not accepted.	Where there is a letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client, so the information is also held elsewhere. Retain for 2 years after the decision is made. Where there is no letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental		Destroy under confidential conditions	N

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	death if patient died while in the care of the organisation.			
Research Records 1. Clinical Trials of Investigational Medicinal Products (CTIMPs)				N
Trial Master File (responsibility of Sponsor & Chief Investigator to ensure that documents are retained)	Five years after the conclusion of the trial	The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006 – sections 18 and 28.	Destroy under confidential conditions	**N**
Research Ethics Committee Records	An ethics committee shall retain all the documents relating to a clinical trial on which it gives an opinion for: (a) where the trial proceeds, at least three years from the conclusion of the trial: or (b) where the trial does not proceed, at least three years from the date of the opinion.	Governance Arrangements for NHS Research Ethics Committees (GAfREC)	Destroy under confidential conditions	**C**
Trial Subject's Medical Files (Sponsor & Chief Investigator's responsibility to ensure retained)	Five years after the conclusion of the trial There should be a flag or divider in health records for documents pertaining to research indicating that the patient has been recruited to a clinical trial or other research		Destroy under confidential conditions	**C**
Marketing authorisation (holders	15 yrs after completion or discontinuation of the trial, **or**	COMMISSION DIRECTIVE 2003/63/EC	Destroy under confidential	**N**

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
must arrange for essential clinical trial documents (including case report forms) other than subject's medical files, to be kept by the owners of the data): Trial subject's medical files	Two years after the granting of the last marketing authorisation in the European Community and when there are no pending or contemplated marketing applications in the European Community, **or** two years after formal discontinuation of clinical development of the investigational product. Retain in accordance with applicable legislation and in accordance with the maximum period of time permitted by the hospital, institution or private practice NB Documents can be retained for a longer period, however, if required by the applicable regulatory requirements or by agreement with the sponsor. It is the responsibility of the sponsor to inform the hospital, institution or practice as to when these documents no longer need to be retained.	(brought into UK law by inclusion in The Medicines for Human Use (Fees and Miscellaneous Amendments) Regulations 2003) – section 5.2(c).	conditions Destroy under confidential conditions	 **N**
All other documentation pertaining to the trial (retention of documentation is the responsibility of the sponsor or other owner of the data) Final Report (responsibility of sponsor or subsequent owner's	Retain as long as the product is authorised. Five years after the medicinal product is no longer authorised.		Destroy under confidential conditions Destroy under confidential conditions	**N**

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
to retain documents)				
2. Data Collected in the Course of Research Data collected in the course of research	Retain for an appropriate period, to allow further analysis by the original or other research teams subject to consent, and to support monitoring by regulatory and other authorities.	Research Governance Framework for Health and Social Care – paragraph 2.3.5. Good Research Practice (MRC Ethics Series, 2000, updated 2005) – paragraph 5.2. Personal Information in Medical Research (MRC Ethics Series, 2000, updated 2003) – chapter 7. Data Protection Act 1998 – Part IV, Section 33 (3).	Destroy under confidential conditions	N
Risk Assessment Records	Retain the latest risk assessment until a new one replaces it.			N
Scanned records relating to to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and		Destroy under confidential conditions	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation. NB Providing the scanning process and procedures are compliant with BSI's BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically once the casenotes have been scanned the paper records can be destroyed under confidential conditions.			
School health records (see Children and young people)				
Sexual Health Records	10 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years	Destroy under confidential conditions	N
Smoking Cessation Records	2 years unless there are clinical indications to keep them for longer		Destroy under confidential	N

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

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Ultrasound records (eg vascular, obstetric)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record **or** 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	S
Vaccination records (see Immunisation and vaccination records)				
Video records/voice recordings relating to patient care/video records/video-conferencing records related to patient care/DVD records related to patient care Includes: Telemedicine records Out of hours records (GP cover) NHS Direct records	8 years subject to the following exceptions or where there is a specific statutory obligation to retain records for longer periods: **Children and young people**: Records must be kept until the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday, **or** until 8 years after the patient's death if sooner **Maternity**: 25 years **Mentally disordered persons**: Records should be kept for 20 years after the date of last contact between patient/client/service user and any	Guidance on use of video-conferencing in healthcare: http://www.wales.nhs.uk/sites/documents/351/1_multipart_xF8FF_3_Guidance%20on%20the%20Use%20of%20Videoconferencing%20in%20Healthcare%20_Ve_.pdf	The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. Video/video-conferencing records should be either permanently archived or	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	healthcare professional **or** 8 years after the patient's death if sooner **Cancer patients**: Records should be kept until 8 years after the conclusion of treatment, especially if surgery was involved. The Royal College of Radiologists has recommended that such records be kept permanently where chemotherapy and/or radiotherapy was given		permanently destroyed by shredding or incineration (having due regard to the need to maintain patient confidentiality).	
Vulnerable Adults (records for)	Where a patient/client/service user is transferred from the care of one NHS or social care organisation to another, all relevant information must be transferred to the patients' health or social care record held at the receiving organisation and they should then be retained for the period of time appropriate to the specialty. Where a patient/client/service user is assessed by a health or social care professional including ambulance personnel and is identified as a vulnerable adult the professional should follow the protocols for dealing with vulnerable adults in their organisation.		Destroy under confidential conditions	N
Ward registers, including daily bed returns (where they exist in paper format)	2 years after the year to which they relate		Likely to have archival value. See note 1	S
X-ray films (including other image formats	General Patient Records – 8 years after conclusion of treatment	BFCR(06)4 – Royal College of Radiologists	Destroy under confidential	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
for all imaging modalities/diagnostics)	Children & Young People – Until the patient's 25th birthday, or if the patient was 17 at conclusion of treatment, until their 26th birthyday or 8 years after the patient's death if sooner. Maternity – 25 years after the birth of the child, including still births Clinical Trials – 15 years after completion of treatment Litigation – Records should be reviewed 10 years after the file is closed. Once litigation has been notified (or a formal complaint received) images should be stored until 10 years after the file has been closed. Mental Health – 20 years after no further treatment considered necessary or 8 years after death. Oncology – see Oncology Records	Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234	conditions	
X-Ray Referral/Request Cards	8 years providing there is a record in the patient's health record that a referral/ request was made for an x-ray	Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say:	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		"It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234		
X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	S
X-ray reports (including reports for all imaging modalities)	To be considered as a permanent part of the patient record and should be retained for the appropriate period of time			S

Based on Royal College guidance

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

British Paediatric Association
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Joint Position on the Retention of Maternity Records

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

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

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

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

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

List of Maternity Records to be Retained

6. Maternity Records retained should include the following:

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

   6.2 documentation recording subsequent antenatal visits and examinations;

   6.3 antenatal in-patient records;

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

   6.5 blood test reports;

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

   6.7 drug prescription and administration records;

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

Annex D2: Business and Corporate (Non-Health) Records Retention Schedule

This retention schedule details a Minimum Retention Period for each type of non-health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. The National Archives (see Note 1 below) should be consulted where a longer period than 30 years is required, or for any pre-1948 records. Organisations should also remember that records containing personal information are subject to the Data Protection Act 1998.

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound):

- administrative records (including personnel, estates, financial and accounting
- records, and notes associated with complaint handling);
- photographs, slides and other images (non-clinical);
- microform (ie microfiche/microfilm);
- audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents

The schedule is split into the following types of records:

Administrative (corporate and organisation)
Biomedical Engineering
Estates/engineering
Financial
IM & T
Other
Personnel/human resources
Purchasing/supplies

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

Notes

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

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
ADMINISTRATIVE (CORPORATE AND ORGANISATION)				
Accident forms (see also Litigation dossiers)	10 years		Destroy under confidential conditions	S
Accident register (Reporting of Injuries,Diseases and Dangerous Occurrencesregister) – see also Incident forms	10 years	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (reg. 7); SocialSecurity (Claims and Payments) Regulations (reg. 25)	Destroy under confidential conditions	C
Adoption records (i.e. administrative records relating the adoption process)	75th anniversary of the date of birth of the child to whom it relates or, if the child dies before attaining the age of 18,15 years beginning with thedate of the 18th birthday	Children and Young Persons Arrangements for Placement of Children (General) (Regulations 1991,SI 1991, No. 890 regs. 8, 9, 10 – children's records) Adoption Regulations 2004(reg. 34)	Destroy under confidential conditions	N
Advance letters (eg DH guidance)	6 years		Destroy	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Agendas of board meetings, committees, sub-committees (master copies,including associated papers)	30 years		See note 1	S
Agendas (other)	2 years		Destroy under confidential conditions	S
Agreements (see Contracts)				
Ambulance Records – Administrative (i.e. records containing non-clinical details only) e.g. records of journeys	2 years from the end of the year to which they relate		Destroy under confidential conditions	N
Annual/corporate reports	3 years		See note 1	S
Appointment Records (GP)	2 years (Provided that any patient-relevant information has been transferred to the patient record) At the end of the 2 year retention period GP practices should consider if there is an ongoing administrative need to keep the records/books for longer. If there IS an ongoing need to retain these records/books, then a		Destroy under confidential conditions – once a decision has been made that there is no ongoing administrative need to retain	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
	further review date should be set (either 1 or 2 more years)		the records.	
Assembly/Parliamentary questions,MP enquiries	10 years		As these documents include all information provided by the organisation in response to a PQ (e.g. background note to the Minister or the Minster may amend the response) all of which may not be used in the response and therefore it will not be in the public domain on House of Commons records they must be destroyed under confidential conditions.	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Audit Records (e.g. Organisational Audits, Records Audits, Systems Audits) – Internal & External in any format (paper, electronic etc)	2 years from the date of completion of the audit		Destroy under confidential conditions	N
Business plans, including local delivery plans	20 years		Destroy	S
Catering forms	6 years		Destroy under confidential conditions	S
Close circuit TV images	31 days	Information Commissioner's Code of Conduct	Erase permanently	S
Commissioning decisions Appeal documentation Decision documentation	 6 years from date of appeal decision 6 years from date of decision		Destroy under confidential conditions	S S
Complaints (See also litigation dossiers) Correspondence, investigation and outcomes Returns made to DH	 8 years from completion of action Files closed annually and kept for 6 years following closure NB: Current policy on the handling of complaints is under review and further guidancewill be issued in due course		Destroy under confidential conditions	C

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Copyright declaration forms (Library Service)	6 years	Copyright, Designs and Patents Act 1988	Destroy under confidential conditions	N
Data Input Forms (where the data/information has been input to a computer system)	2 years		Destroy under confidential conditions	N
Diaries (office)	1 year after the end of the calendar year to which they refer		Destroy under confidential conditions	S
Exposure monitoring records	5 years from the date the record was made	Control of Substances Hazardous to Health Regulations 2002 (reg. 10(5))	Destroy under confidential conditions	S
'Find-a-Doc' records (kept by PCT's) contact sheets and letters assignment cases/letters records of negotiations with GMS contract managers re: patient registration with a GP	 6 months 2 years 2 years		Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Flexi working hours (personal record of hours actually worked)	6 months		Destroy under confidential conditions	S
Freedom of Information requests	3 years after full disclosure; 10 years if information is redacted or the information requested is not disclosed		Destroy under confidential conditions	S
GMS1 forms (registration with GP)	3 years		Destroy under confidential conditions	S
Health and safety documentation	3 years		Destroy under confidential conditions	S
History of organisation or predecessors, its organisation and procedures (eg establishment order)	30 years		See note 1	S
Hospital (trust) services i.e. service that the Trust provides e.g. catering, hotel services	10 years		Destroy	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Incident forms	10 years		Destroy under confidential conditions	C
Indices (records management)	Registry lists of public records marked for permanent preservation, or containing the record of management of public records – 30 years File lists and document lists where public records or their management are not covered – 30 years		See note 1 Destroy under confidential conditions	S S
Laundry lists and receipts	2 years from completion of audit		Destroy under confidential conditions	S
Library registration forms	2 years after registration		Destroy	S
Litigation dossiers (complaints including accident/incident reports) Records/documents relating to anyform of litigation	10 years Where a legal action has commenced, keep as advised by legal representatives		Destroy under confidential conditions	S S
Manuals – policy and procedure (administrative and clinical, strategy documents)	10 years after life of the system (or superseded) to which the policies or procedures refer		Destroy (policy documents may have archival value – see note	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			1)	
Maps	Lifetime of the organisation		See note 1	S
Meetings and minutes papers of major committees and sub-committees (master copies)	30 years		See note 1	S
Meetings and minutes papers (other, including reference copies of major committees)	2 years		Destroy under confidential conditions	S
Mental Health Act Administration Records	5 years NB There is no obligation to treat this type of mental health record as being part of a patient's health record. There may, however, be exceptions, such as where they are required to be kept as evidence in actual or expected litigation or where they are needed by a healthcare professional in order to provide healthcare. Each healthcare practitioner has discretion as to the information which s/he wishes to include as part of a patient record. If in any particular case	HC(91)29 (NHS) SI 2001/3869, reg.47 (Independent Sector)	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
	a healthcare practitioner requires a document which forms part of the mental health act administration record to be included in a patient's record (because he or she regards it as relevant to the patient's healthcare), it should then be regarded as part of the patient' health record			
Mortgage documents (acquisition, transfer and disposal)	6 years after repayment		See note 1	S
Nominal rolls	6 years (maximum)		Destroy under confidential conditions	S
Papers of minor or short-lived importance not covered elsewhere, eg: advertising matter covering letters reminders letters making appointments anonymous or unintelligible letters drafts duplicates of documents known to be preserved elsewhere (unless they have	2 years after the settlement of the matter to which they relate		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
important minutes on them) indices and registers compiled for temporary purposes routine reports punched cards other documents that have ceased to be of value on settlement of the matter involved				
Patient Advice & Liaison Service (PALS) records	10 years after closure of the case		Destroy under confidential conditions	N
Patient information leaflets	6 years after the leaflet has been superseded		See note 1	C
Patients' property books/registers (property handed in for safekeeping)	6 years after the end of the financial year in which the property was disposed of or 6 years after the register was closed		Destroy under confidential conditions	S
Patient Surveys (re access to services etc)	2 years		Destroy under confidential conditions	N
Phone Message Books	2 years		Destroy under	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
	NB Any clinical information should be transferred to the patient health record		confidential conditions	
Police Statements (made in the context of Accident and Emergency episodes. Statements are requested by the Police to the A&E staff in relation to alleged injuries of or by patients coming through A&E)	10 years (congruent retention period as Incident Forms)		Destroy under confidential conditions	N
Press cuttings	1 year		Destroy (where bound volumes exist, see note 1)	S
Press Releases	7 years		see note 1	N
Project files (over £100,000) on termination, including abandoned or deferred projects	6 years		See note 1	S
Project files (less than £100,000) on termination	2 years		Destroy under confidential conditions	S
Project team files (summary retained)	3 years		Destroy under	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			confidential conditions	
Public Consultations e.g. about future provision of services	5 years		Destroy under confidential conditions	N
Quality and Outcomes Framework (QOF) documents (GP Practice records)	2 years		Destroy under confidential conditions	N
Quality assurance records (eg Healthcare Commission, Audit Commission, King's Fund Organisational Audit, Investors in People)	12 years		Destroy under confidential conditions	S
Receipts for registered and recorded mail	2 years following the end of the financial year to which they relate		Destroy under confidential conditions	S
Records documenting the archiving, transfer to public records archive or destruction of records	30 years		See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Records of custody and transfer of keys	2 years after last entry		Destroy under confidential conditions	S
Reports (major)	30 years		See note 1	S
Requests for access to records, other than Freedom of Information or subject access requests	6 years after last action		Destroy under confidential conditions	S
Requisitions	18 months		Destroy under confidential conditions	S
Research ethics committee records	3 years from date of decision		See note 1	C
Serious incident files	30 years		See note 1	S
Specifications (eg equipment, services)	6 years	Limitation Act 1980	Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Statistics (including Korner returns, contract minimum data set, statistical returns to DH, patient activity)	3 years from date of submission		Destroy	S
Subject access requests (DPA and AHR)– records of requests	3 years after last action		Destroy under confidential conditions	S
Surgical appliances forms AP 1, 2, 3 and 4	2 years from completion of audit		Destroy under confidential conditions	S
Time sheets (relating to a Group or Department e.g. Ward where the timesheets are kept as a tool to manage resources, staffing levels)	6 months		Destroy under confidential conditions	N
BIOMEDICAL ENGINEERING				
Sterilix Endoscopic Disinfector Daily Water Cycle Test,	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Sterilix Endoscopic Disinfector Daily Water Purge Test, Nynhydrin Test	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	N
ESTATES/ENGINEERING				
Buildings and engineering works, including major projects abandoned or deferred – key records (eg final accounts, surveys, site plans, bills of quantities)	30 years		See note 1	S
Buildings and engineering works, including major projects abandoned or deferred – town and country planning matters and all formal contract documents (eg executed agreements, conditions of contract, specifications, 'as built' record drawings, documents on the appointment and conditions of engagement of private buildings and engineering consultants)	30 years		See note 1	S
Buildings – papers relating to occupation of the building (but not health and safety information)	3 years after occupation ceases	Construction Design Management Regulations 1994	Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Deeds of title	Retain while the organisation has ownership of the building unless a Land Registry certificate has been issued, in which case the deeds should be placed in an archive If there is no Land Registry certificate, the deeds should pass on with the sale of the building		See note 1	S
Drawings – plans and buildings (architect signed, not copies)	Lifetime of the building to which they relate		See note 1	S
Engineering works – plans and building records	Lifetime of the building to which they relate		See note 1	S
Equipment – records of non-fixed equipment, including specification, test records, maintenance records and logs	11 years If the records relate to vehicles (ambulances, responder cars, fleet vehicles etc) and where the vehicle no longer exists, providing there is a record that it was scrapped, the records can be destroyed	Consumer Protection Act 1987	Destroy under confidential conditions	N
Inspection reports (eg boilers, lifts)	Lifetime of installation If there is any measurable risk of a liability in respect of installations beyond their operational lives, the records should be retained indefinitely		See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Inventories of furniture, medical and surgical equipment not held on store charge and with a minimum life of 5 years	Keep until next inventory		See note 1	C
Inventories of plant and permanent or fixed equipment	5 years after date of inventory		See note 1	S
Land surveys/registers	30 years		See note 1	S
Leases – the grant of leases, licences and other rights over property	Period of the lease plus 12 years	Limitation Act 1980	Destroy under confidential conditions	S
Maintenance contracts (routine)	6 years from end of contract		Destroy under confidential conditions	S
Manuals (operating)	Lifetime of equipment		Review if issues (eg HSE) are outstanding	S
Medical device alerts	Retain until updated or withdrawn (check MHRA website)	www.mhra.gov.uk	Destroy under confidential	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			conditions	
Photographs of buildings	30 years		See note 1	S
Plans – building (as built)	Lifetime of building		May have historical value – see note 1	S
Plans – building (detailed)	Lifetime of building		May have historical value (see note 1)	S
Plans – engineering	Lifetime of building		See note 1	S
Property acquisitions dossiers	30 years		See note 1	S
Property disposal dossiers	30 years		See note 1	S
Radioactive waste	30 years	Radioactive Substances Act 1993	See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Site files	Lifetime of site		See note 1	S
Structure plans (organisational charts) i.e. the structure of the building plans	Lifetime of building		See note 1	C
Surveys – building and engineering works	Lifetime of building or installation		See note 1	S
FINANCIAL				
Accounts – annual (final – one set only)	30 years		See note 1	S
Accounts – minor records (pass books, paying-in slips, cheque counterfoils, cancelled/discharged cheques (for cheques bearing printed receipts, see Receipts), accounts of petty cash expenditure, travel and subsistence accounts, minor vouchers, duplicate receipt books, income records, laundry lists and receipts)	2 years from completion of audit		Destroy under confidential conditions	S
Accounts – working papers	3 years from completion of audit		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Advice notes (payment)	1.5 years		Destroy under confidential conditions	S
Audit records (internal and external audit) – original documents	2 years from completion of audit		Destroy under confidential conditions	N
Audit reports – internal and external (including management letters, value for money reports and system/final accounts memoranda)	2 years after formal completion by statutory auditor		Destroy under confidential conditions	N
Bank statements	2 years from completion of audit		Destroy under confidential conditions	S
Banks Automated Clearing System (BACS) records	6 years after year end		Destroy under confidential conditions	S
Benefactions (records of)	5 years after end of financial year in which the trust monies become finally		See note 1	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
	spent or the gift in kind is accepted. In cases where the Benefaction Endowment Trust fund/capital/interest remains permanent,records should be permanently retained by the organisation			
Bills, receipts and cleared cheques	6 years		Destroy under confidential conditions	S
Budgets (including working papers, reports, virements and journals)	2 years from completion of audit		Destroy under confidential conditions	S
Capital charges data	2 years from completion of audit		Destroy under confidential conditions	S
Capital paid invoices (see Invoices)				
Cash books	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Cash sheets	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Contracts – financial	Approval files – 15 years Approved suppliers lists – 11 years		Destroy under confidential conditions	C
Contracts – non-sealed (property) on termination	6 years after termination of contract	Limitation Act 1980	Destroy under confidential conditions	S
Contracts – non-sealed (other) on termination	6 years after termination of contract	LimitationAct 1980	Destroy under confidential conditions	S
Contracts – sealed (and associated records)	Minimum of 15 years, after which they should be reviewed		See note 1	S
Contractual arrangements with hospitals or other bodies outside the NHS, including papers relating to financial settlements made under the contract (eg waiting list initiative,	6 years after end of financial year to which they relate		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
private finance initiative)				
Cost accounts	3 years after end of financial year to which they relate		Destroy under confidential conditions	S
Creditor payments	3 years after end of financial year to which they relate		Destroy under confidential conditions	S
Debtors' records – cleared	2 years from completion of audit		Destroy under confidential conditions	S
Debtors' records – uncleared	6 years from completion of audit		Destroy under confidential conditions	S
Demand notes	6 years after end of financial year to which they relate		Destroy under confidential conditions	S
Estimates, including supporting calculations	3 years after end of financial year to		Destroy under	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
and statistics	which they relate		confidential conditions	
Excess fares	2 years after end of financial year to which they relate		Destroy under confidential conditions	S
Expense claims, including travel and subsistence claims, and claims and authorisations	5 years after end of financial year to which they relate		Destroy under confidential conditions	S
Fraud case files/investigations	6 years		Destroy under confidential conditions	S
Fraud national proactive exercises	3 years		Destroy under confidential conditions	S
Funding data	6 years after end of financial year to which they relate		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
General Medical Services payments	6 years after year end		Destroy under confidential conditions	S
Invoices	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Ledgers, including cash books, ledgers, income and expenditure journals, nominal rolls, non-exchequer funds records (patient monies)	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Non-exchequer funds records (i.e. funding received by the organisation that does not directly relate to patient care eg charitable funds)	30 years Company charities are required by company law to keep their accounts and accounting records for at least three years but the Charity Commission recommends that they be kept for at least 6 years. The majority of non-company charities must keep their accounts and accounting records for six years (Part VI Charities Act 1993).		Although technically exempt from the Public Records Act, it would be appropriate for authorities to treat these records as if they were not exempt	N
Patient Monies (i.e. smaller sums of donated money)	6 years		Destroy under confidential	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			conditions	
PAYE records	6 years after termination of employment		Destroy under confidential conditions	S
Payments	6 years after year end		Destroy under confidential conditions	S
Payroll (ie list of staff in the pay of the organisation)	6 years after termination of employment		Destroy under confidential conditions For superannuation purposes, organisations may wish to retain such records until the subject reaches benefit age	S
Positive predictive value performance indicators	3 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Private Finance Initiative (PFI)	30 years		See note 1	S
Receipts	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions	S
Salaries (see Wages)				
Superannuation accounts	10 years		Destroy under confidential conditions	S
Superannuation registers	10 years		Destroy under confidential conditions	S
Tax forms	6 years		Destroy under confidential conditions	S
Transport (staff pool car documentation)	3 years unless litigation ensues		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Trust documents without permanent relevance/not otherwise mentioned	6 years		Destroy under confidential conditions	S
Trusts administered by Strategic HealthAuthorities (terms of)	30 years		See note 1	S
VAT records	6 years after end of financial year to which they relate		Destroy under confidential conditions	S
Wages/salary records	10 years after termination of employment		Destroy under confidential conditions For superannuation purposes, organisations may wish to retain such records until the subject reaches benefit age.	S
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TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Documentation relating to computer programmes written in-house	Lifetime of software		Destroy under confidential conditions	S
Software licences	Lifetime of software		Destroy under confidential conditions	S
OTHER				
Chaplaincy records	2 years		May have archival value – see note 1	S
Contractor Applications (Doctors, Dentists, Opticians & Pharmacists)	6 years after end of contract for approvals 6 years for non-approvals.		Destroy under confidential conditions	N
Contractor Records (e.g. Ophthalmic Opticians, Ophthalmic Medical Practitioners, Pharmacists, Pharmacy Premises, General Optical Council	7 years	NHS(General Ophthalmic Services) Regs 1986: A contractor shall keep a proper record in respect of	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
amendments to the register, Previous Pharmacy rotas and supporting information (prior to 2005 – new regulations), Copies of previous Pharmacy and Ophthalmic local lists, Correspondence relating to pharmacies supplying oxygen and visiting Residential/Nursing homes (prior to new regulations)		each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing. Subject to paragraph 8(5) a contractor shall retain all such records for a period of seven years, and shall during that period produce them when required to do so by a Primary Care Trust or the Secretary of State. Follow link below for more detail http://www.dh.gov.uk/assetRoot/04/10/12/ 42/04101242.pdf		
Doctors Postgraduate Educational Allowance/ Personal Development Plan files and supporting general correspondence – Records kept by PCT's	GP Seniority (prior to 2004 – new regulations)	NHS(General Ophthalmic Services) Regs 1986: A contractor shall keep a proper record in respect of each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing. Subject to paragraph 8(5) a contractor shall retain all such records for a period of seven years, and shall during that period produce them when	Destroy under confidential conditions	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
		required to do so by a Primary Care Trust or the Secretary of State. Follow link below for more detail http://www.dh.gov.uk/assetRoot/04/10/12/ 42/04101242.pdf		
Family Health Service Appeals Authority tribunal and case files	Case files – 10 years Decision records – until individual's 80th birthday		See note 1 Destroy under confidential conditions	S
GP retirements/moved away	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday		See note 1	N
Research and development (organisation) i.e. all the organisation's records associated with research and development and not individual trial records or information on patients.	30 years	Medical Research Council	See note 1	N
PERSONNEL/HUMAN RESOURCES				
NB Both medical staff records and agency locums staff records should be treated as personnel records and retained accordingly.				

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Consultants (records relating to the recruitment of)	5 years	NHS (Appointment of Consultants) Regulations, good practice guidelines, page 11, para. 5.3 http://www.dh.gov.uk/assetRoot/04/10/27/ 50/04102750.pdf	Destroy under confidential conditions	S
CVs for non-executive directors (successful applicants)	5 years following term of office		Destroy under confidential conditions	S
CVs for non-executive directors (unsuccessful applicants)	2 years		Destroy under confidential conditions	S
Duty rosters i.e. organisation or departmental rosters, not the ones held on the individual's record.	4 years after the year to which they relate		Destroy under confidential conditions	N
Industrial relations (not routine staff matters), including industrial tribunals	10 years		Destroy under confidential conditions	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
Job advertisements	1 year		Destroy	S
Job applications (successful)	3 years following termination of employment		Destroy under confidential conditions	S
Job applications (unsuccessful)	1 year		Destroy under confidential conditions	S
Job descriptions	3 years		Destroy under confidential conditions	S
Leavers' dossiers	6 years after individual has left Summary to be retained until individual's 70th birthday or until 6 years after cessation of employment if aged over 70 years at the time. The summary should contain everything except attendance books, annual leave records, duty rosters, clock cards, timesheets, study leave applications, training plans	The 6 year retention period is to take into account any ET claims, or EL claims that may arise after the employee leaves NHS employment, requests for information from the NHS pensions agency etc. Claims of this nature can include periods of up to 6 years or more prior to the claim and where evidence could be needed from a	Destroy under confidtial conditions See note 1	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
		number of sources, it is appropriate to retain as much as possible from the original file.		
Letters of appointment	6 years after employment has terminated or until 70th birthday, whichever is later		Destroy under confidential conditions	S
Nurse training records (from hospital-based nurse training schools prior to the introduction of academic-based training)	30 years		See note 1	N
Pension Forms (all)	7 years	HMRC Technical Pension Notes for registered pension schemes under regulation 18 of SI2006/567 – 'RPSM12300020 – Scheme Adminstrator Information Requirements and Adminstration for General Retention of Records'	Destroy under confidential conditions	**N**
Personnel/human resources records –major (eg personal files, letters of appointment, contracts, references and related	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th	The 6 year retention period is to take into account any ET claims, or EL claims that may	See note 1	N

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
correspondence, registration authority forms, training records, equal opportunity monitoring forms (if retained)) NB Includes locum doctors	birthday Summary to be retained until individual's 70th birthday or until 6 years after cessation of employment if aged over 70 years at the time. The summary should contain everything except attendance books, annual leave records, duty rosters, clock cards, timesheets, study leave applications, training plans	arise after the employee leaves NHS employment, requests for information from the NHS pensions agency etc. Claims of this nature can include periods of up to 6 years or more prior to the claim and where evidence could be needed from a number of sources, it is appropriate to retain as much as possible from the original file.		
Personnel/human resources records – minor (eg attendance books, annual leave records, duty rosters (i.e. duty rosters held on the individual's record not the organisation or departmental rosters), clock cards, timesheets (relating to individual staff members)) NB Includes locum doctors	2 years after the year to which they relate		Destroy under confidential conditions	N
Staff car parking permits	3 years		Destroy under confidential conditions	S
Study leave applications	5 years		Destroy under confidential	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			conditions	
Timesheets (for individual members of staff)	2 years after the year to which they relate NB Timesheets (for all individuals including locum doctors) held on the personnel record are minor records – retain for 2 years. Timesheets held elsewhere – i.e. on the ward retain for 6 months (as the master timesheet is held on the personnel file)		Destroy under confidential conditions	N
Training plans	2 years		Destroy under confidential conditions	S
PURCHASING/SUPPLIES				
Approval files (contracts)	6 years after end of the year the contract expired		Destroy under confidential conditions	S
Approved suppliers lists	11 years	Consumer Protection Act 1987	Destroy under confidential	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
			conditions	
Delivery notes	2 years after end of financial year to which they relate		Destroy under confidential conditions	S
Products (liability)	11 years	Consumer Protection Act 1987	Destroy under confidential conditions	S
Stock control reports	18 months		Destroy under confidential conditions	S
Stores records – major (eg stores ledgers)	6 years		Destroy under confidential conditions	S
Stores records – minor (eg requisitions, issue notes, transfer vouchers, goods received books)	18 months		Destroy under confidential conditions	S
Supplies records – minor (eg invitations to	18 months		Destroy under	S

TYPE/SUBTYPE OF RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE
tender and inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery and other supplies)			confidential conditions	
Tenders (successful)	Tender period plus 6 year limitation period	Limitation Act 1980	Destroy under confidential conditions	S
Tenders (unsuccessful)	6 years	Limitation Act 1980	Destroy under confidential conditions	S

Annex D3: Electronic Record/ Audit Trails

1. Electronic records are supported by audit trails, which record details of all additions, changes, deletions and viewings. Typically, the audit trail will include information on:
    - who – identification of the person creating, changing or viewing the record;
    - what – details of the data entry or what was viewed;
    - when – date and time of the data entry or viewing; and
    - where – the location where the data entry or viewing occurred.
2. Audit trails are important for medico-legal purposes as they enable the reconstruction of records at a point in time. Without its associated audit trail, there is no reliable way of confirming that an entry is a true record of an event or intervention.
3. NHS Connecting for Health is considering the impact of the retention of audit trail data, eg whether it should be retained for at least the same period as the data to which it relates. There is also an unresolved issue regarding the association of audit trail data with electronic GP records transferred between practices.
4. Advice and guidance specific to audit trails will be issued in due course on the Department of Health website (http://www.dh.gov.uk/PolicyandGuidance/OrganisationPolicy/RecordsManagement/). In the meantime, NHS organisations are advised to retain all audit trails until further notice.

Annex E: Approved Places of Deposit

'Where an NHS Trust has previously deposited records with a given place of deposit listed here, it should continue to liaise with the same institution unless it receives guidance from The National Archives (TNA) to the contrary. If a Trust is not aware of any previous transfers, or as a result of re-organisation has previously transferred records to more than one place of deposit, it should contact National Advisory Services at TNA (nas@nationalarchives.gov.uk, tel 020 8392 5330 x2620), who will be able to advise which place of deposit should be contacted regarding further transfers. National Advisory Services will also be happy to advise on any other queries regarding the working of the Public Records Act in respect of NHS records.'

A list of all the current appointed Places of Deposit is available on The National Archives website (see below)
http://www.nationalarchives.gov.uk/archives/deposit.htm

The current contact details of these institutions are on The National Archives Archon Directory page (see below)
http://www.nationalarchives.gov.uk/archon/