Surrey Health Informatics Service
Sussex Health Informatics Service

Records Management Explained

A guide to Records Management

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Records Management Explained has been produced as a set of three easy to read booklets conveying the key messages in the *Records Management: NHS Code of Practice*

What NHS staff need to know

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NHS Records retention schedule

The information contained in this booklet was accurate at date of printing (March 2007). It is important that no action should be taken with reference to this document without checking it for accuracy with the Department of Health.

Introduction

Records Management Explained is based on *Records Management: NHS Code of Practice* that was published in March 2006 by the Department of Health.

This booklet is the third in a set of three and 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.

All NHS records are public records under the Public Records Act 1958

Retention periods

The Public Records Act does provide for records which are still in current use to be legally retained. **Records should not ordinarily be kept for longer than 30 years.** 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:

- first entry in file February 2001, last entry in September 2004;
- the retention period is seven years;
- the record should be kept in its entirety until the beginning of 2012.

Each organisation should produce its own retention schedules in the light of its own internal requirements and the NHS guidelines:

- Apply no shorter retention period for any record than the minimum set out in these schedules;
- There may be circumstances to apply a longer retention period;
- The retention period may not exceed 30 years unless prior approval has been obtained via the National Archives;
- Personal data may not be kept for longer than necessary (5th principle of DPA);
- Personal data with historical or statistical research value must be kept as archives (Section 33 of the DPA).

Who makes the decision regarding disposal and destruction of records?

Operational Staff	Staff in the operational area that ordinarily uses the records will usually be able to decide.
Operational Managers	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.
Health Records Committee and/or Health Records User Group	Provide advice on local policy, particularly for the retention, archiving or disposal of sensitive personal health records.
Local Healthcare Professionals	Their input should be a key element of any records management strategy.

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.

Some individual hospitals have themselves been appointed as a Place of Deposit. 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 and Records Group.

It should 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 and Records Group will advise on the current and potential research uses of NHS archives, including patient records.

Keys

New Record type	**N**
Change to the retention period	**C**
Same retention period to a previously existing record type	**S**
Likely to have archival value	*

Health records		
Record type	**Minimum retention period**	**Key**
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 retention period for records of children and young people (below)	N
A&E registers (paper) *	8 years after the year to which they relate	C
Abortion – certificates	3 years A (Form HSA1) and B (Emergency Abortion)	C
Admission books (paper) *	8 years after the last entry	C
Adoption records	see non-health records	
Ambulance records - patient identifiable component	10 years (including paramedic records made on behalf of the Ambulance Service)	N
Asylum seekers and refugees	Special NHS record – patient-held No requirement on NHS to retain	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	N
Autopsy records	see Post mortem records and registers	
Birth registers (register of births kept by the hospital) *	Lists sent to General Register Office on a monthly basis. Retain for 2 years	C
Blood transfusion records	see pathology records	
Body release forms	2 years	N
Breast screening X-rays	8 years	N

Care records - compiled by employees of a Care Trust (including information on an individual's educational status, care needs, etc)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation	N
Cervical screening slides	10 years	N
Chaplaincy records *	2 years	N
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 or8 years after the patient's death if patient died while in the care of the organisation	N
Child Protection Register - records relating to	Retain until the patient's 26th birthday	N
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	S
Clinical audit records	5 years	N
Clinical psychology	30 years	N
Clinical trials of investigational medicinal products - health records of participants that are the source data for the trial	**For trials to be included in regulatory submissions:** At least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the Sponsor. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained	N

Clinical trials of investigational medicinal products - health records of participants that are the source data for the trial	**For trials which are not to be to be used in regulatory submissions:** At least 5 years after completion of the trial. These documents should be retained for a longer period if required by the applicable regulatory requirement(s), the Sponsor or the funder of the trial In either case, if the period appropriate to the specialty is greater, this is the minimum retention period	N
Controlled drug order books	see Pharmacy records	
Controlled drug prescriptions	see Pharmacy records	
Controlled drug registers (ward & pharmacy based)	see Pharmacy records	
Controlled drug ward orders of requisitions	see Pharmacy records	
Counselling records	30 years	N
Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis, including deceased patients	N
Death – Cause of, Certificate counterfoils	2 years	N
Death registers - register of deaths kept by the hospital, (paper) ❋	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	C
Dental epidemiological surveys	30 years	N
Dental, ophthalmic and auditory screening records	11 years for adults For children 11 years or up, to their 25th birthday, whichever is the longer	N
Diaries - health visitors - district nurses	2 years after end of year to which diary relates. Patient relevant information should be transferred to the patient record	N

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	N
Discharge books (paper format) *	8 years after the last entry	C
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	N
Donor records - blood and tissue	30 years post transplantation	N
Drug trials, records	see Clinical trials	
Family planning records	10 years after closure of the case For children retain until their 25th birthday	N
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record)	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 also Human tissue, Post mortem registers	N
Genetic records	30 years from date of last attendance	N
Genito Urinary Medicine (GUM)	8 years from date of last attendance For children retain until 25th birthday	N
GP records, Maternity records	25 years after last live birth	S

GP Records relating to **children** and **young** people	Until the patient's 25th birthday or 26th if an entry was made when the person was 17; or 10 years after death of a patient if sooner (including paediatric, vaccination and community child health service records)	S
GP 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, may then be summarised and kept in summary format for additional 10 year period	S
GP Records relating to those serving in HM **Armed Forces** GP records in existence prior to them enlisting	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 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 retain information that is not relevant to their clinical care of the patient 10 years after their death	S
GP Records relating to those serving a **prison** sentence	Not to be destroyed. This refers to GP records of serving prisoners that were in existence prior to their imprisonment. After their death, the records should be retained for 10 years	S
GP records of **all other patients**	10 years after their death or after the patient has permanently left the country unless the patient remains in the European Union Electronic patient records (EPRs) must not be destroyed, or deleted, for the foreseeable future	S N
Health records (not specified elsewhere in this schedule)	8 years after conclusion of treatment or death	C
Health visitor records	10 years. For children, until their 25th birthday	N
Homicide/serious untoward incident' records	30 years	N

Human fertilisation records, including embryology records	**Treatment centres** 1. If a live child is not born, records should be kept for at least 8 years after conclusion of treatment 2. If a live child is born, records shall be kept for at least 25 years after the child's birth 3. If there is no evidence whether a child was born or not, records must be kept for at least 50 years after the information was first recorded **Storage centres** Where gametes, etc have been used in research, records must be kept for at least 50 years after the information was first recorded **Research centre** Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	N N N
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	N
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	N
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	N
Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis	N

Learning difficulties - records of patients	Retain for 10 years after the death of the individual	N
Macmillan (cancer care) patient records - community and acute	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation	N
Maternity records (all obstetric, midwifery, including maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child	N
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	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. 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 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	C
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	N

Midwifery records	25 years after the birth of the last child	N
Mortuary registers (paper format) *	10 years	N
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 (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
Neonatal screening records	25 years	N
Notifiable diseases book	6 years	N
Occupational health records (staff) *	3 years after termination of employment unless litigation ensues (see page 24)	N
- Health records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	N
- Personal exposure of an identifiable employee monitoring record	40 years from exposure date	N
- Personnel health records under occupational surveillance	40 years from last entry on the record	N
- Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	N
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	N

Oncology (including radiotherapy)	30 years **NB.** Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes	N
Operating theatre registers *	8 years after the year to which they relate	C
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	N
Out of hours records (GP cover), including video, DVD and tape voice recordings	If the only record, retain for 3 years. If placed on other records, retain for period appropriate to the specialty. If required in litigation, see Litigation	N
Outpatient lists (paper)	2 years after the year to which they relate	N
Paediatric records	see Children and young people above	
Parent-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 parent-held records. The records should then be retained until the patient's 25th birthday, or 26th birthday if the young person was 17 at conclusion of treatment, or 8 years after death	N
Pathology records	*Documents, electronic and paper records*	
- Accreditation documents; records of inspections	10 years or until superseded	N
- Batch records results	10 years	N
- Bound copies of reports and records	30 years	N
- Day books and other records of specimens received by a laboratory	2 calendar years	N

- Equipment/instruments maintenance logs, records of service inspections	Lifetime of equipment	N
- Procurement, use, modification, supply records relevant to production of products (diagnostics) or equipment	11 years	N
- External quality control records	2 years	N
- Internal quality control records	10 years	N
- Lab file cards or other working records of test results for named patients	2 calendar years	N
- Near-patient test data	Result in patient record, log retained for lifetime of instrument	N
- Pathological archive or museum catalogues	30 years, subject to consent	N
- Photographic records	30 years where images present the primary source of information for the diagnostic process	N
- Records of telephoned reports	2 calendar years	N
- Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record	N
- Reports, copies	6 months	N
- Post mortem reports	Held in the patient's health record for 8 years after the patient's death	N
- Request forms that are not a unique record	1 week after report received by requestor	N

- Request forms that contain clinical information not readily available in the health record	30 years	N
- Standard operating procedures (current and old)	30 years	N
- *Specimens and preparations* Blocks for electron microscopy	30 years	N
- Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years, stored as a photographic record	N
- Foetal serum	30 years	N
- Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides – 10 years Residual tissue – kept as fixed specimen once frozen section complete	N
- Frozen tissue or cells for histochemical or molecular genetic analysis	10 years	N
- Grids for electron microscopy	10 years	N
- Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)	N
- Microbiological cultures	24–28 days after final report of a positive culture. 7 days for certain specified cultures (RCPath)	N
- Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue obtained through post mortem	N
- Stained slides	Depends on the purpose of the slide – see RCPath document for further details	N

- 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	N
- Paraffin blocks	30 years and then appraise for archival value	N
- Records relating to donor or recipient sera	11 years post transplant	N
- Serum following needlestick injury or hazardous exposure	2 years	N
- Serum from first pregnancy booking visit	1 year	N
- Wet tissue (representative aliquot, whole tissue or organ)	4 weeks after final report for surgical specimens	N
- Whole blood samples, for full blood count	24 hours	N
- *Transfusion laboratories* - Annual reports (where required by EU directive)	15 years	N
- Autopsy reports, specimens, archive material and other where 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	N
- Blood bank register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	N
- Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4ºC	N

- Forensic material criminal cases	Permanently, not part of the health record	N
- Refrigeration and freezer charts	11 years	N
- Request forms for grouping, antibody screening and crossmatching	1 month	N
- Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used	N
- Separated serum/plasma, stored for transfusion purposes	Up to 6 months	N
- Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	N
- Worksheets	30 years to allow full traceability of all blood products use	N
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	N
Pharmacy records *Prescriptions* - Chemotherapy	Individual retention periods from Hospital Pharmacists Group 2003 2 years after last treatment	N N
- Clinical drug trials (non-sponsored)	2 years after completion of trial	N
- FP10, TTOs, outpatient, private	2 years (Inpatient prescriptions held as part of health record)	N
- Parenteral nutrition	2 years (hold with health record)	N

- Unlicensed medicines dispensing record	5 years	N
- *Worksheets* Raw material request and control forms	5 years	N
- Resuscitation box	1 year after expiry of the longest dated item	N
- Chemotherapy, aseptics worksheets, parenteral nutrition, production batch records	5 years	N
- Paediatric	As per children and young people	N
- *Quality Assurance* Environmental monitoring results	1 year after expiry date of products	N
- Equipment validation	Lifetime of the equipment	N
- QC documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	N
- Refrigerator temperature	1 year	N
- Standard operating procedures	15 years after superseded by revised version	N
- *Orders* Invoices	6 years	N
- Order and delivery notes, requisition sheets, old order books	Current financial year plus one	N
- Picking tickets, delivery notes	3 months	N
- Ward pharmacy requests	1 year	N
- *Controlled Drugs* Controlled drug destruction records	2 years (pharmacy and ward based)	N

- Controlled drug prescriptions (TTOs/OP)	2 years	N
- Controlled drug order books, ward orders and requisitions	2 years	N
- Controlled drug registers (pharmacy and ward)	2 years	N
Photographs (where the photograph refers to a particular patient it should be treated as part of the health 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	N
Physiotherapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation	N
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	N
Post mortem records	See Pathology records	
Post mortem registers *	30 years (paper format)	N
Prison healthcare records	See GP records	
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	N

Psychology records	30 years	N
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed	C
Records of destruction of individual health records (case notes) and other health-related records contained in this retention schedule (manual or computer)	Permanently	N
Research records 1. Other than clinical trials of investigational medicinal products, health records of participants that are the source data for the research	30 years	N
2. Research records and research databases (not patient specific) Research records other than for clinical trials of investigational medicinal products –as above	Clinical trials of investigational medicinal products – at least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the sponsor. It is the responsibility of the sponsor to inform the investigator /institution as to when these documents no longer need to be retained	N
Scanned records relating to patient care	Retain for period of time appropriate to patient/ specialty, 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 patient's death if patient died while in care of the organisation	N
School health records	See Children and young people	

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	N
Suicide notes	10 years (of patients having committed suicide)	N
Telemedicine records (see Video records)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per 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
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 3 years	C
Ultrasound records (eg vascular, obstetric)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per 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
Vaccination records	See Immunisation and vaccination records	

Video records / voice recordings relating to patient care / video-conferencing records (see also Telemedicine records and Out of hours records)	8 years subject to the following exceptions: **Children and young people:** Records must be kept until the patient's 25th birthday, or if patient was 17 at the conclusion of treatment, until their 26th birthday, or until 8 years after 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 and any healthcare professional or 8 years after the patient's death if sooner **Cancer patients:** Records should be kept until 8 years after the conclusion of treatment, especially if surgery was involved. The Royal College of Radiologists has recommended that such records be kept permanently where chemotherapy and/or radiotherapy was given	N
Ward registers, Including daily bed returns (paper format) *	2 years after the year to which they relate	C
X-ray films (including other image formats for all imaging modalities/ diagnostics)	7 years	N
X-ray registers (paper format) *	30 years	C
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	N

Maternity Records to be retained

- booking data and pre-pregnancy records
- antenatal visits and examinations
- antenatal in-patient records
- clinical test results, ultrasonic scans, alpha-feto protein, chorionic villus sampling
- blood test reports
- intrapartum records (initial assessment, partograph,cardiotocographs)
- drug prescription and administration records
- postnatal records, relating to the care of mother and baby, in hospital and community settings.

Business and Corporate (Non - Health) Records Retention Schedule		
Administrative (Corporate and organisational) records		
Accident forms (also Litigation dossiers)	10 years	S
Accident register (Reporting of Injuries, Diseases and Dangerous Occurrences)	8 years see also Incident forms	C
Adoption records	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 the date of the 18th birthday	N
Advance letters (eg DH guidance)	6 years	S
Agendas of board meetings, committees, sub-committees	30 years (master copies, associated papers)	C
Agendas (other)	2 years	C
Agreements	see Contracts	
Annual corporate reports	3 years	C
Assembly/Parliamentary questions, MP enquiries	10 years	N
Business plans, including local delivery plans	20 years	N
Catering forms	6 years	N
Close circuit TV images	31 days	N
Commissioning decisions - Appeal documentation - Decision documentation	 6 years from date of appeal decision 6 years from date of decision	N N N
Complaints - Correspondence, investigation and outcomes - Returns made to DH (see also Litigation dossiers)	10 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 guidance will be issued in due course	S

Copyright declaration forms	1 year after employee leaves	N
Diaries (office)	1 year after end of calendar year to which they refer	S
Exposure monitoring records	5 years from date the record was made	N
Flexi working hours (personal record of hours actually worked)	6 months	S
Freedom of Information requests	3 years after full disclosure; 10 years if information is redacted or the information requested is not disclosed	N
GMS1 forms (registration with GP)	3 years	N
Health and safety documentation	3 years	N
History of organisation or predecessors, its organisation and procedures	30 years (eg establishment order)	C
Hospital (trust) services	10 years	S
Incident forms	8 years	N
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	C C

Laundry lists and receipts	2 years from completion of audit	S
Library registration forms	2 years after registration	N
Litigation dossiers (complaints including accident/incident reports)	10 years	S
Records/documents relating to any form of litigation	Where a legal action has commenced, keep as advised by legal representatives	N
Manuals - policy and procedure (administrative; clinical; strategy)	10 years after life of the system (or superseded) to which the policies or procedures refer	N
Maps	Lifetime of the organisation	N
Meetings and minutes papers of major committees and sub-committees	30 years (master copies)	C
Meetings and minutes papers (other, including reference copies of major committees)	2 years	C
Mortgage documents (acquisition; transfer; disposal)	6 years after repayment	N
Nominal rolls	6 years (maximum)	S
Papers of minor or short-lived importance not covered elsewhere, eg: - advertising matter - covering letters - reminders - letters making appointments	2 years after the settlement of the matter to which they relate	N

Papers of minor or short-lived importance not covered elsewhere, eg: - anonymous or unintelligible letters - drafts - duplicates of documents known to be preserved elsewhere (unless they have 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	2 years after the settlement of the matter to which they relate	N
Patient information leaflets	Lifetime of the organisation	N
Patients' property register (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	N
Press cuttings	1 year	S
Project files (over £100,000) on termination, including abandoned or deferred projects	6 years	C
Project files (less than £100,000) on termination	2 years	C
Project team files (summary retained)	3 years	C

Quality assurance records (eg Healthcare Commission, Audit Commission, King's Fund Org Audit, Investors in People)	12 years	N
Receipts for registered and recorded mail	2 years following end of financial year to which they relate	N
Records documenting the archiving, transfer to public records archive or destruction of records	30 years	N
Records of custody and transfer of keys	2 years after last entry	N
Reports (major)	30 years	N
Requests for access to records, other than FOI or subject access requests	6 years after last action	N
Requisitions	18 months	S
Research ethics committee records	30 years from date of decision	N
Serious incident files	30 years	N
Specifications (equipment and services)	6 years	S
Statistics (Including Coroner returns, contract minimum data set, statistical returns to DH, patient activity)	3 years from date of submission	S
Subject access requests (DPA and AHR) - records of requests	3 years after last action	N
Surgical appliances forms AP 1, 2, 3 and 4	2 years from completion of audit	S
Time sheets	6 months	C

Estates / Engineering records		
Buildings and engineering works, including major projects abandoned or deferred – key records	30 years (eg final accounts, surveys, site plans, bills of quantities)	C
Buildings and engineering works, including major projects abandoned or deferred - town and country planning matters and all formal contract documents	30 years (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)	C
Buildings - papers relating to occupation of the building (not health and safety information)	3 years after occupation ceases	S
Deeds of title	Retain while the organisation has ownership of 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 sale of the building	C
Drawings plans and buildings (architect signed, not copies)	Lifetime of building to which they relate	C
Engineering works - plans and building records	Lifetime of the building to which they relate	C
Equipment - records of non-fixed equipment, (specification, test records, maintenance records, logs)	11 years	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	C

Inventories of furniture, medical and surgical equipment not held on store charge, with a minimum life of 5 years	30 years after date of inventory	C
Inventories of plant and permanent or fixed equipment	5 years after date of inventory	C
Land surveys/registers	30 years	C
Leases – the grant of leases, licences and other rights over property	Period of the lease plus 12 years	C
Maintenance contracts (routine)	6 years from end of contract	N
Manuals (operating)	Lifetime of equipment	S
Medical device alerts	Retain until updated or withdrawn (check MHRA website)	N
Photographs of buildings	30 years	C
Plans – building (as built)	Lifetime of building	C
Plans – building (detailed)	Lifetime of building	S
Plans – engineering	Lifetime of building	S
Property acquisitions dossiers	30 years	C
Property disposal dossiers	30 years	C
Radioactive waste	30 years	N
Site files	Lifetime of site	C
Structure plans (organisational charts)	Lifetime of building	C
Surveys - building & engineering works	Lifetime of building or installation	C

Financial records		
Accounts - annual (final, one set only)	30 years	C
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	S
Accounts - working papers	3 years from completion of audit	S
Advice notes (payment)	1.5 years	S
Audit records – original	2 years from completion of audit	S
Audit reports – external (including management letters, value for money reports and system/final accounts memoranda)	2 years after formal completion by statutory auditor	S
Bank statements	2 years from completion of audit	S
Banks Automated Clearing System (BACS) records	6 years after year end	N

Benefactions (records of)	5 years after end of financial year in which the trust monies become finally 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	C
Bills, receipts, cleared cheques	6 years	S
Budgets, (including working papers, reports, virements, journals)	2 years from completion of audit	S
Capital charges data	2 years from completion of audit	S
Capital paid invoices	see Invoices	
Cash books	6 years after end of financial year to which they relate	S
Cash sheets	6 years after end of financial year to which they relate	S
Contracts – financial	Approval files – 15 years Approved suppliers lists – 11 years	C
Contracts – non-sealed (property) on termination	6 years after termination of contract	S
Contracts – non-sealed (other) on termination	6 years after termination of contract	S
Contracts – sealed (and associated records)	Minimum of 15 years, after which they should be reviewed	C
Contractual arrangements with hospitals or other bodies outside the NHS, including papers relating to financial settlements made under the contract (eg waiting list initiative, private finance initiative)	6 years after end of financial year to which they relate	N
Cost accounts	3 years after end of financial year to which they relate	S
Creditor payments	3 years after end of financial year to which they relate	S
Debtors' records - cleared	2 years from completion of audit	S
Debtors' records - uncleared	6 years from completion of audit	S
Demand notes	6 years after end of financial year to which they relate	S

Estimates, including supporting calculations and statistics	3 years after end of financial year to which they relate	S
Excess fares	2 years after end of financial year to which they relate	N
Expense claims, including travel and subsistence claims, and claims and authorisations	5 years after end of financial year to which they relate	S
Fraud case files/investigations	6 years	N
Fraud national proactive exercises	3 years	N
Funding data	6 years after end of financial year to which they relate	S
General Medical Services payments	6 years after year end	N
Invoices	6 years after end of financial year to which they relate	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	S
Non-exchequer funds records	30 years	C
PAYE records	6 years after termination of employment	S
Payments	6 years after year end	N
Payroll (ie list of staff in the pay of the organisation)	6 years after termination of employment	S
Positive predictive value performance indicators	3 years	N
Private Finance Initiative	30 years	N
Receipts	6 years after end of financial year to which they relate	S
Salaries	see Wages	
Superannuation accounts	10 years	S

Superannuation forms SD55(ADP) & SD55J (NHS Pensions Scheme - copies)	10 years (original to NHS Pensions Agency)	S
Superannuation registers	10 years	S
Tax forms	6 years	S
Transport (staff pool car documentation)	3 years unless litigation ensues	N
Trust documents without permanent relevance - not otherwise mentioned	6 years	S
Trusts administered by SHA (terms of)	30 years	C
VAT records	6 years after relevant financial year	S
Wages/salary records	10 years after termination of employment	S
Personnel / Human Resources records		
Consultants (records relating to the recruitment of)	5 years	N
CVs for non-executive directors (successful applicants)	5 years following term of office	S
CVs for non-executive directors (unsuccessful applicants)	2 years	S
Duty rosters	4 years	N
Industrial relations, including industrial tribunals	10 years (not routine staff matters)	C
Job advertisements	1 year	S
Job applications (successful)	3 years after termination of employment	S
Job applications (unsuccessful)	1 year	N

Job descriptions	3 years	S
Leavers' dossiers	6 years after individual has left Summary retained for 30 years or until 70th birthday, whichever is later	S C
Letters of appointment	6 years after employment has terminated or until 70th birthday, whichever is later	N
Nurse training records	30 years	S
Personnel HR records **major** personal files - letters of appointment - contracts - references - related correspondence - registration authority forms - training records - equal opportunity monitoring forms	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday	N
Personnel HR records **minor** - attendance books - annual leave records - duty rosters - clock cards - timesheets	2 years	N
Staff car parking permits	3 years	N
Study leave applications	5 years	S
Timesheets	6 months	N
Training plans	2 years	N

Purchasing / Supplies records		
Approval files (contracts)	6 years after end of year contract expired	C
Approved suppliers lists	11 years	S
Delivery notes	2 years after financial year end they relate	C
Products (liability)	11 years	S
Stock control reports	18 months	S
Stores records – **major** (eg stores ledgers)	6 years	S
Stores records – **minor** - requisitions - issue notes - transfer vouchers - goods received books	18 months	S
Supplies records – **minor** - invitations to tender - inadmissible tenders - routine papers relating to catering - demands for furniture equipment, stationery and other supplies	18 months	S
Tenders (successful)	Tender period plus 6 year limitation period	C
Tenders (unsuccessful)	6 years	S
Information Management and Technology (IM & T) records		
Documentation relating to computer programmes written in-house	Lifetime of software	N
Software licences	Lifetime of software	S
Other records		
Chaplaincy records ❋	2 years	N
Family Health Service Appeals Authority tribunal and case files	Case files – 10 years Decision records – until 80th birthday	N
Research and development (organisation)	30 years	C

Where to go for guidance

Electronic Record / Audit Trails

Advice and guidance specific to audit trails will be issued as soon as possible on the Department of Health website.
www.dh.gov.uk

In the meantime, NHS organisations are advised to retain all audit trails until further notice.
Keeper of Public Records - National Archives
www.nationalarchives.gov.uk

The Health Archives and Records Group
www.archives.org.uk

The Royal College of Pathologists
www.rcpath.org.uk

Hospital Pharmacists Group (Royal Pharmaceutical Society of Great Britian)
www.rpsgb.org.uk

MHRA – Medicines and Healthcare products Regulatory Agency
www.mhra.gov.uk

This booklet, as part of a set of three, has been produced by
Surrey Health Informatics Service and Sussex Health Informatics Service

Published March 2007