



# **Records Management Policy**

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## Contents:

SECTION 1 General Information .....	2
SECTION 2 NHS Borders Records Management Standards .....	3
SECTION 3 Confidentiality .....	4
SECTION 4 Document Storage/Destruction Schedules .....	5
<u>Administrative Records</u> .....	7
2 General Records .....	8
3 Financial Records .....	9
4 Property Environment and Health & Safety Records .....	12
5 Human Resources Records .....	17
6 Procurement & Stores Records .....	19
7 NHS Board Records .....	20
8 Service Planning .....	23
<u>Personal Health Records</u> .....	24
NHS Borders Local Retention Periods.....	24
Guidance on legal minimum periods for document types [Listed Alphabetically].....	25
SECTION 5 Audit and Training .....	44
Audit .....	44
Training .....	44
SECTION 6 Data Protection .....	45
Eight Data Protection Principles .....	45
Six Caldicott Principles .....	45
Confidentiality Security Advisory Group [2002] Code of Practice .....	45
Appendix 1 Definition of Records .....	46
Appendix 2 Essential Maternity Record Retention Policy .....	47
Appendix 3 Principles of File Creation & Tracking .....	49
Appendix 4 Additional Guidance on Registers & Preservation of Records / Useful Reference Sites .....	50
Appendix 4 Links to Useful Reference Sites .....	50

## **SECTION 1**

### **General Information**

1. In the context of this Policy, a record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees - including consultants, agency, or casual staff.
2. Managers should undertake an audit of their record keeping and storage arrangements, to plan retention / destruction programme for their files.
3. Staff in these areas should follow the guidelines on record management in this policy. Where these are duplicates of centrally held records, a local destruction and retention policy may be applied based on departmental operational requirements.
4. Documents for destruction containing patient/person identifiable information or confidential or sensitive information whose uncontrolled disclosure may pose a risk to the business of the NHS Borders, including duplicates, must be shredded, or placed in confidential waste bags for disposal as per the "Waste Collection Instructions " procedure 8.3 of the Infection Control Manual.
5. The retention periods given are only "minimum recommendations" and discretion should be applied before any documentation is culled.
6. Documents of historical importance must not be destroyed and should be annotated clearly to that effect
7. Documents not included in Section 4 of this policy are those of minor or ephemeral importance  

e.g. advertising or correspondence. Drafts, duplicates of documents known to have been preserved elsewhere unless they have important minutes/annotation on them, indices/registers compiled for temporary purposes, routine reports and other documents which have ceased to be of value on the matter involved are also not included.

Destruction of these documents should comply with the process outlined in Paragraph 4 above

8. When in doubt regarding the classification of a record prior to culling, refer to the Head of Department, or for general queries to the Senior Health Information Manager for further guidance
9. Section 4 details the minimum length of time paperwork should be kept. The guidance is taken from the Scottish Health Service circular NHS HDL (2006)28 and the Records Management Code of Practice [Scotland] 2008.
10. Where items are being retained, they should be boxed and clearly labelled showing the type of material stored, the date of storage and the destruction date, where appropriate.
11. The Caldicott Guardian, Data Protection Lead, Senior Health Information Manager and persons responsible for non-clinical records will meet at least annually to review compliance with reports going to the Director of Performance & Planning.
12. NHS Borders is committed to producing an organisation-wide strategy for both clinical and non-clinical records.

## **SECTION 2**

### **NHS Borders Records Management Standards**

It is vitally important that you always:

- record any important and relevant information, making sure that it is complete
- ensure that it is legible so that it can easily be read and reproduced when required
- put it where it can be found when needed
- keep it up to date – procedures and policies should have production date and review dates stated
- if necessary, share information rather than copying it in order to reduce risks to confidentiality
- suitably dispose of records as soon as possible (subject to agreed retention periods)

Good record keeping ensures that:

- time is not spent hunting for information;
- there is an “audit trail” which enables any record entry to be traced to a named individual at a given date/time with the secure knowledge that all alterations can be similarly traced;
- those coming after you can see what has been done, or not done, and why; and
- any decisions made can be justified or reconsidered at a later date.

This is vitally important in cases such as:

- providing patient care;
- clinical liability;
- parliamentary accountability;
- purchasing and contract or service agreement management;
- financial accountability; and
- disputes or legal action

Additional guidance on good practice for clinical record keeping can be found in the NHS Borders Completion of Clinical Records Policy.

[http://intranet.borders.scot.nhs.uk/Doc\\_Library/Public/policies/completion\\_health\\_records\\_policy.pdf](http://intranet.borders.scot.nhs.uk/Doc_Library/Public/policies/completion_health_records_policy.pdf)

### **SECTION 3**

#### **Confidentiality**

1. Records should never be left insecure and unattended
2. All staff should have confidentiality issues, including Data Protection Act 1998 and role of Caldicott Guardian explained locally, at induction and ultimately sign a confidentiality form. One copy should be retained in personnel file and one retained by employee (See Section 6 for Principles)
3. Staff are issued with identification badges containing photograph, name, designation and department
4. Information held on computer systems may only be accessed by authorised users with all major systems being password protected.
5. Access to computer systems is granted to users according to duties and level of responsibility
6. Levels of access is as agreed by the Departmental Manager and I.T. Manager
7. Passwords are changed regularly [See IT Security Policies for additional guidance]
8. Each System Manager will hold a register of authorised users for computer systems along with their access rights (i.e. read, update, delete to specific/all records). Department Managers must ensure that amendments to this list are notified the IM&T Service Desk when either staff or levels of access change.
9. Staff are reminded not to leave confidential information on the computer screen and to utilize password controlled screen-savers for added protection.
10. Each department will hold a register of authorised signatories, which will be updated annually and retained as per documents referred to.
11. Confidential information must not be given by telephone unless the identity of the requestor is known to have a genuine need-to-know. If in doubt, request telephone number and check for authenticity before passing on information. Messages should never be left on answering machines unless identity of recipient is known
12. Faxes containing person-identifiable information should not be transmitted except where it would not be safe to remove person-identifiable information. Generally if faxing, all person-identifiable information should be deleted, ensure a fax-cover sheet is attached and follow up with personal details by telephone.
13. Information passed between Health Boards etc. should be via the Safe- Haven arrangements.
14. Information sharing outwith the NHS, such as with Regional Council Departments should only be in accordance with agreed protocols, and where required, the individual's explicit consent should be obtained
15. Staff must take all reasonable precautions to ensure security and confidentiality if records have to be transported:
  - Confidential records should be sent via Recorded Delivery
  - Internal envelopes must never be used to send confidential information.
16. All confidential documentation which has to be destroyed, must be shredded, or placed in confidential waste bags and disposed as per the " Waste Collection Instructions " procedure 8.3 of the Infection Control Manual.

## SECTION 4

### Document Storage

1. Physical Records Storage should be in a building of sound construction that has appropriate physical security measures in place [ locks / +/- alarms]
2. Temperature and humidity controls should be in place.
3. Appropriate drainage to prevent a build up of water, or risk of flooding
4. The risk from any exposed pipes needs to be assessed and mitigated
5. Appropriate fire protection systems should be in place
6. Cleanliness - area should be neat, orderly and dust free
7. Appropriate equipment should be in place to access and handle records safely.
8. Back-up Storage media should be in fire safes and stored in a separate location from the processors
9. Main File server areas should have appropriate fire suppression systems in place

### Destruction Schedules Introduction

The destruction of records is an irreversible act, while the cost of preserving records worthy of permanent preservation is high and continuing. The criteria, which follow, are intended to give guidance on how long records should be kept for business purposes and on the identification of records of permanent value.

Managers must ensure that records no longer required for business use are reviewed as soon as practicable under the criteria set out below so that ill-considered destruction is avoided. This schedule identifies **minimum** retention periods. The review will determine whether records are to be selected for permanent preservation, destroyed or retained for research or litigation purposes.

Whenever the schedule is used, the guidelines listed below should be followed and consideration of requirements under FOISA [see below]:

- i. Business requirements must be considered before activating retention periods in this schedule.
- ii. Decisions should also be considered in the light of the need to preserve records, whose use cannot be anticipated fully at the present time, but which may be of value to future generations.
- iii. Recommended minimum retention periods should be calculated from the end of the calendar or accounting year following the last entry on the document.
- iv. The selection of files for permanent preservation is partly informed by precedent (the establishment of a continuity of selection) and partly by the historical context of the subject (the informed identification of a selection).
- v. The provisions of the Data Protection Act 1998 must also be complied with.

## **Freedom of Information (Scotland) Act 2002 (FOISA) .**

Copies of any information, documents or records held by NHS Borders may be requested by the public under the Freedom of Information (Scotland) Act 2002 (FOISA). The Act is completely retrospective, which means that a request can be made for a copy of any document, irrespective of when it was produced. NHS Borders would be in breach of FOISA if we were unable to provide the requested document because it had been destroyed unlawfully or inappropriately. In order to remain in compliance with FOISA, it is essential that the document destruction schedules and authorisation guidelines set out in this Records Management Policy are adhered to.

## **Administrative Records**

[Extract from Circular HDL(2006)28]

- 2 General Records
- 3 Financial Records
- 4 Property, Environment and Health & Safety Records
- 5 Human Resources Records
- 6 Procurement & Stores Records
- 7 NHS Board Records
- 8 Service Planning

## 2. General Records

Record Type	Minimum Retention Period	Notes
Conferences: lectures given by staff at other conferences	permanent	
Conferences: organised by Boards - conference proceedings	permanent	
Conferences: organised by Boards - routine paperwork	destroy after conference	
Conferences: other conferences attended by staff	2 years	
Copies of out-letters (“flimsies”)	1 year	
Databases- records handling system	permanent	Retain to demonstrate implementation of established practice and provide audit trail, see also Indexes
Diaries - office	1 year after completion	
Indexes- file and document lists marked for permanent preservation	permanent	
Indexes- file and document lists not marked for permanent preservation	Destroy when no longer useful	Retention may be required if they are part of audit trails
Quality Assurance Records	12 years	
Receipts for registered and recorded delivery mail	2 years	
Records of custody and transfer of keys	2 years	
Research and development (scientific, technological and medical)	Consider for permanent preservation	
Software licenses	Operational lifetime of product	

### 3. Financial Records

The Scottish Executive policy on retention of financial records is set out in the Scottish Public Finance Manual, which can be accessed at: <http://www.scotland.gov.uk/library5/finance/spfm/spf-00.asp>

Financial records are required to be maintained for 3 years after the end of the financial year in question. Records relating to VAT however require to be kept for 6 years and in practice it may be difficult to differentiate VAT records from other financial records.

Record Type	Minimum Retention Period	Notes
Accounts – final annual master copies	permanent	
Accounts - cost	3 years	
Accounts - working papers	3 years	
Accounts - minor records: (including <ul style="list-style-type: none"> <li>• pass books,</li> <li>• paying-in slips,</li> <li>• cheque counterfoils, cancelled/discharged cheques,</li> <li>• petty cash expenditure,</li> <li>• travelling and subsistence accounts, minor vouchers,</li> <li>• duplicate receipt books,</li> <li>• income records,</li> <li>• laundry lists)</li> </ul>	3 years after completion of audit	See 'Receipts for cheques bearing printed receipts' below
Accounts - statutory final	permanent	
Advice Notes	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes
Audit records - original documents	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes
Audit reports (including Management letters, VFM reports and system/final accounts memorandum)	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes
Bank statements	3 years after completion of audit	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Benefactions – endowments, legacies gifts etc.	permanent	
Bills and receipts	6 years	
Budget monitoring reports	3 years	
Budgets	2 years after completion of audit	
Capital paid invoices	3 years	See ‘Invoices’ below
Cash books and sheets	6 years	
Cost accounts		See ‘Accounts’ above
Creditor payments	3 years	
Debtors' records - cleared	6 years	
Debtors' records - uncleared	6 years	
Demand Notes	6 years	
Expenses claims		See ‘Accounts – minor’ Above
Financial plans, estimates recovery plans	6 years	
Funding data	6 years	
General ledgers	6 years	
Income and expenditure sheets and journals	6 years	
Indemnity Forms	6 years after the indemnity has lapsed	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Inquiries involving fraud/other irregularities	10 years	Where action is in Prospect or has been commenced, consult with legal representatives and NHS Counter Fraud Services and keep in accordance with advice provided
Invoices payable (creditors)	6 years	
Invoices receivable (debtors)	6 years	
Ledgers	6 years	See also 'General ledgers' above
Mortgage documents - acquisition, transfer and disposal	permanent	
Non-exchequer funds records		See 'Income and Expenditure journals' above
PAYE records	6 years	
Receipts	6 years	Includes cheques bearing printed receipts
SFR returns	6 years	
Superannuation- accounts and registers	10 years	
Superannuation - forms	10 years	
Tax forms	6 years	
VAT records	6 years	In some instances a shorter period may be allowed, but agreement must be obtained from Customs & Excise
Wages/salary records	10 years	For superannuation purposes authorities, may wish to retain such records until the subject reaches pensionable age

#### 4. Property, Environment and Health and Safety Records

Record Type	Minimum Retention Period	Notes
Agreements		See 'Contracts' below
Buildings - papers relating to occupation	Permanent or until property demolished or disposed	Does not include Health & Safety information
Capital charges data	3 years after completion of previous 5 year valuation term	
Contaminated Land	permanent	
Contracts - non sealed (property) on termination	6 years	
Environmental Information	permanent	
Equipment		See 'Products – liability' under 'Procurement Records'
Estimates: including supporting calculations and statistics	3 years	
Greencode	permanent	
Health and safety: Asbestos Register	permanent	
Health and safety: Audit forms, COSHH (Control of Substances Hazardous to Health Regulations) documentation, safety risk data sheets, risk assessments and control measures etc.	10 years	
Health and Safety: Accident and Incident Forms	10 years	See 'Litigation dossiers' under 'NHS Board Records'
Health and Safety: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) including Accident Register	10 years	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Inspection Reports - e.g. boilers, lifts etc.	2 years after operational lifetime of installation / plant	Should be retained indefinitely if there is any measurable risk of a liability
Inventories (non-current) of items having an operational lifetime of less than 5 years	2 years	
Land purchase and sale - deeds, leases, maps, surveys, registers etc	permanent	
Land purchase and sale - negotiations not completed	6 years	
Laundry lists		See 'Accounts – minor' under 'Financial Records'
Manuals - operating		See 'Inspection reports' Above
Manuals- policy and procedure	permanent	
Maintenance contracts		See 'Property- Cleaning and Maintenance' below
Maintenance request book	2 years after financial year referred to	
Maps	consider for permanent preservation	
Project files (£250,000 and over)	Permanent	Including abandoned or deferred projects
Project files (under £250,000)	6 years after completion / abandonment of project	
Project team files (£250,000 and over)	3 years	
Project team files (under £250,000)	3 years	
Property - acquisitions dossiers	permanent	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Property - cleaning and maintenance (contracts less than £100,000)	6 years	
Property - disposal dossiers	permanent	
Property/ Estates- Land, Building and Engineering Construction Procurement: <ul style="list-style-type: none"> <li>• Key records (including: <ul style="list-style-type: none"> <li>○ final accounts,</li> <li>○ surveys,</li> <li>○ site plans,</li> <li>○ bills of quantities,</li> <li>○ PFI/PPP records)</li> </ul> </li> <li>• Town and country planning matters and all formal contract documents (including: <ul style="list-style-type: none"> <li>○ executed agreements,</li> <li>○ conditions of contract,</li> <li>○ specifications,</li> <li>○ "as built" record drawings and documents on the appointment and conditions of engagement of private buildings and engineering consultants)</li> </ul> </li> </ul>	permanent	Inclusive of major projects abandoned or deferred
Property - leases	permanent	
Property management system	permanent	
Property - minor contracts	6 years	
Property performance	permanent	
Property - purchases	permanent	
Property strategy	permanent	



<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Property - title deeds	permanent	
Property- Terriers (NHS Premises Site Information)	permanent	
Safety Action Bulletins	permanent	
SEPA Registrations, Licenses and Consents	permanent	
Specifications for work tendered	6 years	
Tenders (successful)		See 'Contracts' above
Tenders (unsuccessful)	6 years	
Waste Consignment Notes- Controlled wastes such as clinical/ healthcare and household/ domestic	2 years	
Waste Consignment Notes- Special/ Hazardous/ Radioactive Wastes	3 years	
Waste- Duty of Care Inspection Reports	permanent, or for life of external contract	

## 5. Human Resources Records

Record Type	Minimum Retention Period	Notes
Disciplinary: First written warning	6 months	
Disciplinary: Final written warning	12 months	
Disciplinary: First and final written warning	12 months	
Disciplinary: Letter of Dismissal	10 years	Where action is in prospect or has been commenced, consult with legal representatives and keep in accordance with advice provided.
Disciplinary: Records of action taken, including: <ul style="list-style-type: none"> <li>• Details of rules breached</li> <li>• Employee's defence or mitigation</li> <li>• Action taken and reasons for it</li> <li>• Details of appeal and any subsequent developments</li> </ul>	6 years after leaving service	See above for retention periods for warnings.
Establishment records - major (including: <ul style="list-style-type: none"> <li>• Personnel files,</li> <li>• letters of application and appointment,</li> <li>• confirmation of qualifications, contracts,</li> <li>• joining forms,</li> <li>• references &amp; related correspondence,</li> <li>• termination forms)</li> </ul>	6 years after leaving service	
Establishment records - minor (including: <ul style="list-style-type: none"> <li>• attendance books,</li> <li>• annual leave records,</li> <li>• duty rosters,</li> <li>• clock cards,</li> <li>• timesheets)</li> </ul>	2 years	
Industrial relations (not routine)	permanent	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Personal Development: Nurses - training records	40 years after completion of training	
Personal Development: Study leave applications	2 years	
Recruitment: Applications for employment- unsuccessful applicants	1 year after completion of recruitment procedure	
Recruitment: CVs for non-executive directors (successful)	5 years following end of term of office	
Recruitment: CVs for non-executive directors (unsuccessful applicants)	2 years	
Recruitment: Disclosure Scotland information	6 months	Six months after the date on which recruitment or other relevant decisions have been taken; or six months after the date on which recruitment or other relevant decisions have been taken.
Recruitment: Job advertisements	1 year	

## 6. Procurement and Stores Records

Record Type	Minimum Retention Period	Notes
Approval files - contracts	permanent	
Approved suppliers lists	11 years	
Delivery notes	2 years	
Indents	2 years after financial year referred to	
Medical equipment specifications - major items purchased	permanent	
Medical Equipment - operating manuals	operational lifetime of equipment	
Procurement documentation	7 years	One copy of each supplier response from short listed to tender and the contract itself.
Products - liability	11 years	
Purchase orders	3 years after financial year referred to	
Requisitions	2 years after financial year referred to	
Stock control reports	2 years	
Stores - major (ledgers etc.)	6 years	
Stores - minor (requisitions, issue notes, transfer vouchers, goods received books etc.)	2 years	
Supplier correspondence	6 years after termination of agreement	
Supplies records - minor (e.g. invitations to tender and inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery and other supplies)	2 years	

## 7. NHS Board Records

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Area health plans	permanent	
Contracts - non sealed on termination	6 years	
Contracts- GP Practices and others to deliver core NHS services	permanent	
Contracts – sealed	permanent	Including associated records
Corporate policies	permanent	
Deeds of title	permanent	
Health promotion – core papers and visual materials relating to major initiatives	consider permanent preservation	
History of Boards or their predecessor organisations	permanent	
History of hospitals	permanent	
Hospital services files	consider permanent preservation	
Legal actions (adult)	7 years after case settled or dropped	
Legal actions (child)	until child is 18 or 7 years after case settled or dropped, whichever is later	
Litigation dossiers - complaints including accident reports	10 years	Where a legal action has commenced see Legal actions
Meeting papers - master set	permanent	Main committees and sub-committees of NHS Boards and special Health Boards and other meetings of significance for legal, administrative

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
		or historical reasons
Minutes - master set	permanent	Main committees and sub-committees of NHS Boards and special Health Boards
NHS circulars - master set	permanent	
Nursing homes pre 1 April 2002: registration documents and building plans	permanent	The regulation of care services was taken over by the Care Commission on 1 <sup>st</sup> April 2002.
Nursing homes pre 1 April 2002: inspection reports and general correspondence	5 years	The regulation of care services was taken over by the Care Commission on 1 <sup>st</sup> April 2002.
Option appraisals	6 years after end of agreement	
Patient complaints without litigation -adults	7 years	
Patient complaints without litigation – children and young adults	until child is 16 or 7 years, whichever is later	
Photographs	consider for permanent preservation	Corporate and publicity photographs, not used those for patient care purposes.
Press cuttings	consider for permanent preservation	
Register of seals	permanent	
Reports - major	permanent	
Serious incident files	permanent	
Service development reports	6 years	
Service level agreements	6 years	

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Strategic plans	permanent	
Subject files	permanent	Files relating directly to the formulation of policy and major controversies must be permanently preserved. Other files should be disposed of when no longer needed.
Trust arrangements legally administered by NHS organisations - documents describing terms of foundation/ establishment and winding-up	permanent	
Trusts arrangements legally administered by NHS organisations - other documents	6 years	

## 8. Service Planning

<b>Record Type</b>	<b>Minimum Retention Period</b>	<b>Notes</b>
Activity monitoring reports	6 years after end of agreement	
Admission, transfer and treatment of patients- policy files	permanent	
Databases - demographic and epidemiological based on data supplied by NHS National Service Scotland, Information Services		In accordance with general policies of NHS National Service Scotland, Information Services, and any specific terms and conditions imposed by them in relation to particular data sets
Databases - demographic and epidemiological based on survey data		May be retained indefinitely if data quality and potential for future re-use justifies cost of migration / regeneration to new formats and platforms
Patient activity data	3 years	
Summary bed statistics	permanent	
Waiting list monitoring reports	6 years	
Winter business plans	6 years	

## Personal Health Records

Throughout this Schedule, where the 'standard' retention period specified above applies, the relevant record type has the entry 'Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)' in the 'Minimum Retention Period' column. Where it does not apply, the required minimum retention period is listed in the 'Minimum Retention Period' column.

### Notes:

1 – Record is likely to have permanent research and historical value, consult NHS archivist or National Archives of Scotland.

Record Type [NHS Borders local Policy]	Timescale	Advice Source / Comments
1] Children And Young Adults Aged Less Than 16 Years At Date Of Admission	Retain until the person reaches the age of 25 years. [Local decision to also include records of deceased]	Legal requirement 3 years post death but national cases of abuse suggests this is inadequate
2] Obstetric Records (Records Of Mother)	Retain for 25 years after the birth of the child (including stillbirths)	
3] Records Of Cancer Patients	Retain for the lifetime of the patient and 3 years after death	
4] Colposcopy Records	Retain indefinitely	
5] Deceased Patients Records	With the exception of those identified in 2 and 4 retain for 3 years after death. Confirmation of Death must be sought from the CHI system pre destruction	
6] Patients From:  Borders Lothian Dumfries Northumberland Lanark	Destroy contents of records after 6 years from date of last attendance, with the following exceptions which are to be retained for a further 4 years before destruction: All Typed Correspondence Operation Record First And Last E.C.G. Of Each Episode Of Care Anaesthetic Records 'Purple' Histology Reports Photographs – E.G. Pigmented Lesions Blood Transfusion Records All Orthopaedic Typed Records In The Case Record Section Of The Medical Records Folder	
7] Patients From Areas Other Than Those Detailed In 6 Above	Destroy all records 6 years following the date of last attendance	
8] Retained Deads .	Retained indefinitely at the request of consultant	Highlighted Using 'RETAIN STICKERS'
9] Mental Health Records	Retain	

## Health Records Retention Schedule<sup>1</sup>

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
A&E records (where these are stored separately from the main patient record)	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
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 [Page 22]
Abortion – Certificates set out in Schedule 1 to the Abortion (Scotland) Regulations 1991	3 years beginning with the date of the termination	
Admission books (where they exist in paper format)	8 years after the last entry	Likely to have archival value- see Note 1 [Page 22]
Ambulance records – patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	7 years	
Asylum seekers and refugees (NHS personal health record – patient held record)	Special NHS record- patient held, no requirement on the NHS to retain	
Audiology records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Birth registers (ie register of births kept by the hospital)	2 years	Likely to have archival value- see Note 1 [Page 22]
Body release forms	2 years	
Breast screening Xrays	8 years	
Cervical screening slides	10 years	

<sup>1</sup> Source Scottish Government NHS Code of Practice [Scotland] Version 1.0 June 2008

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Chaplaincy records	2 years	Likely to have archival value-see Note 1 [Page 22]
Child and family guidance	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Child Protection Register (records relating to)	Retain until the patient's 26 <sup>th</sup> birthday	
Clinical audit records	5 years	
Clinical psychology	30 years	
Clinical trials of investigational medicinal products – health records of participants that are the source data for the trial	<p><b>For trials to be included in regulatory submissions:</b> 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. <b>For trials which are not to be used in regulatory submissions:</b> 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.</p>	Likely to have archival value-see Note 1 [Page 22]
Counselling records	30 years	Likely to have archival value-see Note 1 [Page 22]
Death – Cause of, Certificate counterfoils	2 years	
Death registers – i.e.	2 years	Likely to have archival value-see Note 1 [Page 22]

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
register of deaths kept by the hospital, where they exist in paper format		
Dental epidemiological surveys	30 years	
Dental, ophthalmic and auditory screening records	Adults: 11 years Children: 11 years, or up to 25 <sup>th</sup> birthday, whichever is the longer	
Diaries – health visitors and district nurses	2 years after end of year to which diary relates.  Patient relevant information should be transferred to the patient record.	It is not good practice to record patient identifiable information in diaries.
Dietetic and nutrition	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Discharge books (where they exist in paper format)	8 years after the last entry	Likely to have archival value- see Note 1 [Page 22]
District nursing records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Donor records (blood and tissue)	30 years post transplantation	Likely to have archival value- see Note 1 [Page 22]
Family planning records	10 years after the closure of the case  For children retain until their 25 <sup>th</sup> birthday	
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Procurator Fiscal's report, and	For postmortem records which form part of the Procurator Fiscal's report, approval should be sought from the PF for a copy of the report to be incorporated in the patient's notes, which should then be kept in the pathology laboratory, and then reviewed.	Likely to have archival value- see Note 1 [Page 22]

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	All other records retain for 30 years.	
Genetic records	30 years from date of last attendance.	Likely to have archival value- see Note 1 [Page 22]
Genito Urinary Medicine (GUM)	Store according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
GP records, including medical records relating to HM Armed Forces	<p>Retain for the lifetime of the patient and for 3 years after their death.</p> <p><b>Records relating to those serving in HM Armed Forces -</b></p> <p>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 is a matter for their professional judgement, taking into account clinical need and Data Protection Act requirements- they should not, for example, retain information that is not relevant to their clinical care of the patient.</p> <p>GP records of serving military personnel in existence prior to them enlisting must not be destroyed. Following the death of the patient the records should be retained for 3 years.</p> <p><b>*Electronic Patient Records (EPRs)- GP only-</b> must not be destroyed, or deleted, for the</p>	<p>* The rationale for this is explained in ‘SCIMP Good Practice Guidelines for General Practice Electronic Patient Records - section6.1</p>

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
	foreseeable future	
Health visitor records	10 years Records relating to children should be retained until their 25 <sup>th</sup> birthday	
Homicide/‘serious untoward incident’ records	30 years	Likely to have archival value- see Note 1 [Page 22]
Hospital acquired infection records	6 years	
Human fertilisation records, including embryology records	<p><b>Treatment Centres</b></p> <ol style="list-style-type: none"> <li>1. If a live child is not born, records should be kept for at least 8 years after conclusion of treatment</li> <li>2. If a live child is born, records shall be kept for at least 25 years after the child’s birth</li> <li>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</li> </ol> <p><b>Storage Centres</b></p> <p>Where gametes etc have been used in research, records must be kept for at least 50 years after the information was first recorded.</p> <p><b>Research Centres</b></p> <p>Records are to be kept for 3 years from the date of final report of results/ conclusions to Human Fertilisation and Embryology Authority (HFEA)</p>	Likely to have archival value- see Note 1 [Page 22]
Human tissue (within the meaning of the Human Tissue	For post mortem records which form part of the Procurator Fiscal’s report, approval should be sought from the	Likely to have archival value- see Note 1 [Page 22]

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
(Scotland) Act 2006) (see Forensic medicine above)	Procurator Fiscal 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.	
Intensive Care Unit charts	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
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.	Likely to have archival value- see Note 1 [Page 22]
Learning difficulties – (records of patients with)	Retain for 3 years after the death of the individual.	
Macmillan (cancer care) patient records – community and acute	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
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 Notes
Medical illustrations (see Photographs below)	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Mentally disordered persons (within the meaning of any Mental Health Act )	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Microfilm/microfiche records relating to patient care	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	Likely to have archival value-see Note 1 [Page 22]
Midwifery records	25 years after the birth of the last child	
Mortuary registers (where they exist in paper format)	10 years	Likely to have archival value-see Note 1 [Page 22]
Music therapy records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Neonatal screening records	25 years	
Notifiable diseases book	6 years	
Occupational Health Records (staff)	6 years after termination of employment	
Health Records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have archival value-see Note 1 [Page 22]
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	Likely to have archival value-see Note 1 [Page 22]
Personnel health records under occupational surveillance	40 years from last entry on the record	Likely to have archival value-see Note 1 [Page 22]
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have archival value-see Note 1 [Page 22]
Occupational therapy records	Retain according to the standard minimum retention period	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
	appropriate to the patient/ specialty (see Above)	
Oncology (including radiotherapy)	30 years  N.B. Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes.	Likely to have archival value- see Note 1 [Page 22]
Operating theatre registers	8 years after the year to which they relate	Likely to have archival value- see Note 1 [Page 22]
Orthoptic records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Out of hours records (GP cover), including video, DVD and tape voice recordings	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate	
Parent held records	There should be a copy kept at the NHS organisation responsible for delivering that care and compiling the record of the care.  The records should then be retained until the patient's 25 <sup>th</sup> birthday, or 26 <sup>th</sup> birthday if the young person was 17 at the conclusion of treatment, or 3 years after death	
<b>Pathology records</b>		
<i>Documents, electronic and paper records</i>		
Accreditation documents; records of inspections	10 years or until superseded	
Batch records results	10 years	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Bound copies of reports/records, if made	30 years	
Day books and other records of specimens received by a laboratory	2 calendar years	
Equipment/ instruments maintenance logs, records of service inspections  Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	Lifetime of equipment  11 years	
External quality control records	2 years	
Internal quality control records	10 years	
Lab file cards or other working records of test results for named patients	2 calendar years	
Near-patient test data	Result in patient record, log retained for lifetime of instrument	
Pathological archive/museum catalogues	30 years, subject to consent	
Records of telephoned reports	2 calendar years	
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Reports, copies  Post mortem reports	6 months  Held in the patient's health record for 8 years after the patient's death	
Request forms that are not a unique record	1 week after report received by requestor	
Request forms that contain clinical information not readily available in the health record	30 years	
Standard operating procedures (current and old)	30 years	
<i>Specimens and preparations</i>		
Blocks for electron microscopy	30 years	
Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record	
Foetal serum	30 years	
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides- 10 years Residual tissue- kept as fixed specimen once frozen section complete	
Frozen tissues or cells for histochemical or molecular genetic analysis	10 years	
Grids for electron microscopy	10 years	
Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Microbiological cultures	24-28 days after final report of a positive culture issued. 7 days for certain specified cultures- see RCPATH document	
Museum specimens (teaching collections)  Stained slides	<p>Permanently. Consent of the relative is required if it is tissue obtained through post mortem</p> <p>Depends on the purpose of the slide- see RCPATH document for further details</p> <p><a href="http://www.rcpath.org/resources/pdf/g031the%20retention%20and%20storage%20of%20pathological%20records%20and%20archives%203rd%20ed%20with%20revision%20oct%202006.pdf">http://www.rcpath.org/resources/pdf/g031the%20retention%20and%20storage%20of%20pathological%20records%20and%20archives%203rd%20ed%20with%20revision%20oct%202006.pdf</a></p>	
Newborn blood spot screening cards  Body fluids/ aspirates/ swabs	<p>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</p> <p>48 hours after the final report issued by lab</p>	
Paraffin blocks	30 years and then appraisal for archival value	
Records relating to donor or recipient sera	11 years post transplant	
Serum from first pregnancy booking visit	1 year	
Wet tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens	
Whole blood samples, for full blood count	24 hours	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
<i>Transfusion laboratories</i>		
Annual reports (where required by EU directive)	15 years	
Autopsy reports, specimens, archive material and other where the deceased has been the subject of Procurator Fiscals autopsy	These are Procurator Fiscal's records- copies may only be lodged on the health record with the PF's permission.	
Blood bank register, blood component audit trail and fates	30 years to allow full traceability of all blood products used.	
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4° C	
Forensic material – criminal cases	Permanently- not part of the health record	
Refrigeration and freezer charts	11 years	
Request forms for grouping, antibody screening and crossmatching	1 month	
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used	
Separated serum/plasma, stored for transfusion purposes	Up to 6 months	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Storage of material following analyses of nucleic acids	30 years  See RCPATH document for further guidance  <a href="http://www.rcpath.org/resources/pdf/g031the%20retention%20and%20storage%20of%20pathological%20records%20and%20archives%203rd%20ed%20with%20revision%20oct%202006.pdf">http://www.rcpath.org/resources/pdf/g031the%20retention%20and%20storage%20of%20pathological%20records%20and%20archives%203rd%20ed%20with%20revision%20oct%202006.pdf</a>	
Worksheets	30 years to allow full traceability of all blood products used	
<b>end of Pathology records</b>		
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 patient/ specialty (see Above).	
<b>Pharmacy Records</b>		
<i>Prescriptions</i>		
Chemotherapy	2 years after last treatment	
Clinical drug trials (non-sponsored)	2 years after completion of trial	
GP10, TTO's, outpatient, private	2 years	N.B. Inpatient prescriptions held as part of health record.
Parenteral nutrition	2 years	Original valid prescription to be held with the health record.
Unlicensed medicines dispensing record	5 years	
<i>Worksheets</i>		

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Raw material request and control forms	5 years	
Resuscitation box	1 year after the expiry of the longest data item  Applies only to re-packaged items.	
Chemotherapy, aseptic worksheets, parenteral nutrition, production batch records	5 years	NHS organisations should be aware of product liability which means that if a defective product was likely to have affected the health of a patient, then the patient's record would have to be retained for at least 13 years (Prescription and Limitation (Scotland) Act 1973 as amended by the Consumer Protection Act 1987 )
Paediatric	As per Children and Young People (see Above)	
<i>Quality Assurance</i>		
Environmental monitoring results	1 year after expiry date of products	
Equipment validation	Lifetime of the equipment	
QC Documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	
Refrigerator temperature	1 year	Refrigerator records to be retained for the life of any product stored therein
Standard operating procedures	5 years after superseded by revised version	
<i>Orders</i>		
Invoices	6 years	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Order and delivery notes, requisition sheets, old order books	Current financial year plus one	
Picking tickets/ delivery notes	3 months	
Ward Pharmacy requests	1 year	
<i>Controlled Drugs</i>		
Controlled drug destruction records (pharmacy and ward based)	2 years	
Controlled drug prescriptions (TTOs/OP)	2 years	
Controlled drug order books, ward orders and requisitions	2 years	
Controlled drug registers (pharmacy and ward based)	2 years	
<i>Other</i>		
Medicines information enquiry	10 years	
<b>(end of Pharmacy)</b>		
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record)	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Physiotherapy records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	

<b>TYPE OF HEALTH RECORD</b>	<b>MINIMUM RETENTION PERIOD</b>	<b>NOTE</b>
Podiatry records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
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 [Page 22]
Private patient records admitted under section 57 of the National Health Service (Scotland) Act 1978 or section 5 of the National Health Service (Scotland) Act 1947 (now repealed)	It would be appropriate for authorities to retain these according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Psychology records	30 years	Likely to have archival value-see Note 1 [Page 22]
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed.	Likely to have archival value-see Note 1 [Page 22]
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	Likely to have archival value-see Note 1 [Page 22]
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	Likely to have archival value-see Note 1 [Page 22]  Review patient identifiable records every 5 years to see if they need to be retained or if their identifiability could be reduced.

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
2. Research records and research databases (not patient specific)	<p><b>Clinical trials of investigational medicinal products</b></p> <p>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 retained.</p> <p><b>Research records other than for clinical trials of investigational medicinal products</b></p> <p>As above.</p>	Likely to have archival value- see Note 1 [Page 22]
Scanned records relating to patient care	Retain in main records and retain for the period of time according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
School health records (see Children and young people)	Retain in Child Health Records	
Speech and language therapy records	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	
Telemedicine records (see also Video records)	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
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	Likely to have archival value- see Note 1 [Page 22]
Ultrasound records (e.g. vascular, obstetric)	Retain according to the standard minimum retention period appropriate to the patient/ specialty (see Above)	
Video records/ voice recordings relating to patient care/video-conferencing records (see also Telemedicine records and Out of hours records)	<p>8 years subject to the following exceptions:</p> <p><b>Children and Young People-</b> Records must be kept until the patient's 25<sup>th</sup> birthday, of the patient was 17 at the conclusion of treatment until their 26<sup>th</sup> birthday, or until 3 years after the patient's death if sooner.</p> <p><b>Maternity-</b> 25 years</p> <p><b>Mentally disordered persons-</b> Records should be kept for 20 years after the date of last contact between patient/ client/ service user and any healthcare professional or 3 years after the patient's death if sooner.</p> <p><b>Cancer patients-</b> 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.</p>	The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. Video/ video-conferencing records should be either permanently archived or permanently destroyed by shredding or incineration (having due regard to the need to maintain patient confidentiality)
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 [Page 22]

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Xray films (excluding PACS images)	The minimum retention period for these can continue to be determined locally by the NHS organisation responsible. In setting the minimum retention period, appropriate recognition should be given to current professional guidance, clinical need, special interest groups, cost of storage and the availability of storage space.	
Xray – PACS images	<p><b>National:</b></p> <p>PACS images captured as part of the national PACS programme are stored in a central national archive in accordance with the National PACS for Scotland Image Retention/ Storage Policy, which is subject to annual review by the PACS Clinical Advisory Group.</p> <p><b>Local:</b></p> <p>Locally set minimum retention periods can continue to apply to PACS images that are not captured as part of the national PACS programme.</p>	As eHealth strategic developments progress, this guidance, along with that for other record types affected, will be reviewed.
Xray registers (where they exist in paper format)	30 years	Likely to have archival value- see Note 1 [Page 22]
Xray reports (including reports for all imaging modalities)	<p>To be considered as part of the patient record.</p> <p>Retain according to the standard minimum retention period appropriate to the patient/ specialty (see above)</p>	

## **SECTION 5 Audit and Training**

### **Audit**

Regular audits will be carried out on compliance with this Policy.

Areas to be targeted will be in accordance with an assessment of level of potential risk to NHS Borders' business.

Audit reports and any remedial action plans will be passed to Risk Management Board.

Director of Performance Management will be responsible for audit arrangements.

The departments included are:

1. Wards and Departments
2. Corporate Planning
3. Estates
4. Finance
5. Health and Safety
6. Personnel
7. Pharmacy
8. Stores

### **Training**

All staff will receive training on record management on their initial induction as contained in the generic induction pack.

Staff will receive further training as deemed appropriate by their departmental manager and this will be recorded in their personnel file.

Update sessions will be offered as appropriate to the requirements of their role, taking cognisance of any new legislation.

Guidance on the management of clinical and non-clinical records will be posted on the Clinical Intranet and this will be brought to the attention of all new recruits at induction, and to existing staff when in place.

## **SECTION 6 Data Protection**

### **Eight Data Protection Principles**

1. Personal data shall be processed **fairly** and **lawfully**
2. Personal data shall be obtained only for one or more **specified** and **lawful** purposes and shall not be further processed in any manner incompatible with that purpose or those purposes
3. Personal data shall be **adequate, relevant** and **not excessive** in relation to the purpose or purposes for which they are processed
4. Personal data shall be **accurate** and, where necessary, **kept up-to-date**
5. Personal data processed for any purpose or purposes shall **not be kept for longer than is necessary** for that purpose or those purposes
6. Personal data shall be processed in accordance with the **rights of the data subject** under this Act
7. Appropriate **technical** and **organisational measures** shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data
8. Personal data shall **not be transferred** to a country or territory outside the European Economic Area **unless** that country or territory **ensures an adequate level of protection** for the rights and freedoms of data subjects in relation to the processing of personal data

### **Six Caldicott Principles**

1. Justify the purpose(s) for using confidential information
2. Only use it when absolutely necessary
3. Use the minimum that is required
4. Access should only be on a strict need-to-know basis
5. Everyone must understand his or her responsibilities
6. Understand and comply with the law

### **Confidentiality Security Advisory Group [2002] Code of Practice**

1. Patients should be the source of their data
2. Inform patients of their rights & responsibilities
3. Obtain consent
4. Record no more information than necessary
5. Get it Right
6. Keep it Secure
7. Share With Care
8. Provide for Patient Access to Records
9. Know Your Obligations

For more detailed information, contact the Data Protection Lead

## **Appendix 1 Definition of Records**

What sorts of records does the guide cover?

In the context of this Policy, a record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees (HSC 1999/053 - including consultants, agency, or casual staff.

The policy covers all information gathered including:

- Personal health records. This includes the personal health records of private patients seen on NHS premises. [DQ: Check]
- Registers e.g. Accident & Emergency, Theatre and Birth Registers.
- Administrative records e.g. personnel, estates, financial and accounting records.
- Complaints files.
- X-Ray and Imaging reports, output and images
- Photographs, slides, and other images.
- Microform (i.e. fiche / film).
- Audio and videotapes, cassettes, CD-ROM etc.
- Computer databases, output, and disks, etc. and all other electronic records.
- Material intended for short term or transitory use, including notes and 'spare copies' of documents.

(It is important to remember that the ownership and copyright in these records as a rule is with the NHS Board, not with any individual employee or contractor.)

## **Appendix 2 Essential Maternity Record Retention Policy**

Reproduced below is the joint position on the retention of maternity records as agreed by the British Paediatric Association, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the United Kingdom Central Council for Nursery, Midwifery and Health Visiting and specified in the Department of Health publication: 'Records Management: NHS Code of Practice' (270422/2/Records Management: NHS Code of Practice Part 2).

### **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 that 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**

Maternity Records retained should include the following:

- a) documents recording booking data and pre-pregnancy records where appropriate;
- b) documentation recording subsequent antenatal visits and examinations;
- c) antenatal inpatient records;

- d) clinical test results including ultrasonic scans, alpha-feto protein and chorionic villus sampling;
- e) blood test reports;
- f) all intrapartum records to include, initial assessment, partograph and associated records including cardiotocographs;
- g) drug prescription and administration records;
- h) postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.

### Appendix 3 Principles of File Creation & Tracking

We all spend most of our working lives creating, collecting, and recording information - whether that is via a simple note of a telephone conversation, a large report, or personal data about a specific patient or their treatment - but each of these records is only as valuable as the information it contains, and that is only of value if it can be found when needed, and then used effectively. Good quality records management is important and each individual has a key role to play in maximising benefits to patient care through effective record keeping.

Individual documents may be registered, but it is normal practice to create a file (folder, box-file, etc.) to hold all the documents on each subject, and to register the file(s) for each series.

The best practice principles of registration of files and procedures are:

- the file title must be unique
- the reference identity assigned to each file must be unique
- both must be relevant to and easily understood by all users
- the identifier should be restricted to no more than four elements
- each element should relate to a different hierarchical level of the file title details should be recorded both on the file cover and in the register.

At a minimum the file description should identify:

- its title
- its registration identifier (e.g. number or prefix used in register) the date it was registered (opened)
- the date it is due to be closed and reviewed, destroyed, or archived.

#### File Tracking

Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently. One of the main reasons why records get misplaced or lost is because their next destination is not recorded anywhere.

Tracking mechanisms should record the following (minimum) information:

- the item reference number or other identifier
- a description of the item (e.g. the file title)
- the person, unit or department, or place to whom it is being sent the date of the transfer to them

When a record is in constant or regular use, or is likely to be needed quickly, it makes sense to keep it within the area responsible for the related work. Storage equipment for current records will usually be adjacent to users i.e. their desk drawers or nearby cabinets, to enable information to be appropriately filed so that it can be retrieved when it is next required. Records must always be kept securely and when an area containing records is left unattended, the records should be secured. A sensible balance should be achieved between the needs for security and accessibility.

## **Appendix 4 Additional Guidance on Registers & Preservation of Records**

In the light of the recent trends of medical and historical research, it may be appropriate to select some of these records for permanent preservation. Selection should be performed in consultation with health professionals, and NHS archivists. If records are to be sampled, specialist advice should be sought from the same health professionals and archivists. If a NHS Board has taken on a leading role in the development of specialised treatments, then the patient records relating to these treatments may be especially worthy of permanent preservation.

If a whole run of patient records is not considered worthy of permanent preservation but nevertheless contain some material of research value, then the option of presenting these records to a NHS Board or local authority archive would be considered.

If a whole run of patient records is considered worthy of permanent preservation but there is a lack of space in the relevant place of deposit to store these records, it may be appropriate to make a microfilm copy and then destroy the paper originals. Microfilms should be produced in accordance with the British and International Standard BS ISO 6199: 1991, copies of which can be purchased from the British Standards Institute.

Useful reference documents:-

- NHS Circular HDL(2006)26 'The Management, Retention and Disposal of Administrative Records' issued in May 2006 .  
[http://www.sehd.scot.nhs.uk/mels/HDL2006\\_28.pdf](http://www.sehd.scot.nhs.uk/mels/HDL2006_28.pdf)
- Records Management: NHS Code of Practice [Scotland] 2008 The Code of Practice can be accessed at the following link  
<http://www.scotland.gov.uk/Publications/2008/07/01082955/0>

Guidance on Records Management can be obtained locally via the IM&T Service Desk:

Tel:- 01896 82777      [IM&T Service Desk](#)